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UPPER PAYMENT LIMITS: FEDERAL MEDICAID SPENDING FOR NON-MEDICAID PURPOSES

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BEFORE THE

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UPPER PAYMENT LIMITS: FEDERAL MEDICAID SPENDING FOR NON-MEDICAID PURPOSES

WEDNESDAY, SEPTEMBER 6, 2000

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:07 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Grassley, Moynihan, Breaux, and Bryan.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will please come to order.

Over the next 5 weeks, this committee will be busy with a number of important legislative priorities. But before we become too immersed in the legislative challenges ahead of us, an urgent problem in the Medicaid program demands our immediate oversight attention.

Through the inappropriate use of aggregate upper payment limits, some States have been using the Medicaid program to fill in holes in State budgets. This has turned a program intended to provide health coverage to vulnerable, low-income pregnant women, children, senior citizens, and individuals with disabilities into a bank account for State projects having nothing to do with health care.

In fact, as I examine the current situation, I am vividly reminded of the Medicaid spending scandals we confronted 10 years ago when disproportionate share hospital program dollars were used to build roads, bridges, and highways.

Let me be very clear: this cannot, and will not, be permitted to continue. To help us understand this complicated accounting mechanism and the impact it has had on the fiscal integrity of the Medicaid program, we will first hear from the Office of the Inspector General at the Department of Health and Human Services, and the General Accounting Office. Mr. Mangano and Ms. Allen, thank you for joining us.

Then we will hear, of course, from Tim Westmoreland, head of the Center for Medicaid and State Operations at the Health Care Financing Administration. Mr. Westmoreland has done more than anyone else to identify the problems we confront, and I look for-

ward to hearing how and when the administration intends to solve them.

Now, these problems may seem dry and technical, but let me assure you, the consequences are enormous. If unchecked, we face a situation that fundamentally undermines the fiscal integrity of the Medicaid program and circumvents the traditional partnership of financial responsibility shared between the Federal and State governments.

Now, our witnesses will explain the mechanics of the financing scheme in greater detail. But before they do so, I do want to state that I have been advised that what States are doing is technically not illegal. The States are taking advantage of a loophole in HCFA regulations.

Well, it is time to close that loophole. We must act, because nearly 40 million Americans rely on Medicaid for needed health care services. The program must not be undermined and weakened by clever consultants and State budgeteers; too much is at stake.

Several months ago, I began working with the administration to respond to this scandal. We must stop it in its tracks, while of course at the same time working thoughtfully and carefully with those States that have become dependent on the revenues generated through the use of upper payment limits to help them transition to a more sustainable payment relation with the State and Federal Government.

But I have become frustrated by the fact that, so far, we have heard a lot of talk from the administration, but frankly have seen very, very little action. I was told in May that the administration would take the steps needed to shut down this loophole through a notice of proposed rulemaking that was to have been released in June. In June, I was told it would be out in July. In July, I was led to expect action in August. Well, it is now September.

Let me say to my friends in the administration, it is time to stop delaying. It is time to act. Each day that goes by without action is another day in which the program exploitation becomes more institutionalized. A problem that goes unchecked simply becomes harder to solve. Frankly, by the failure to solve it, I think some States can almost saying to the Governor, you ought to act because you are not doing the same thing your brethren are doing.

HCFA costs because of this problem are probably $2.2 billion this current year, and it could amount to $12 billion over 5 years. We owe it to the 40 million Medicaid beneficiaries and to the American taxpayers to step up to the plate and get the job done. I call upon the administration to live up to its responsibility.

With that, I am happy to turn to my good friend and colleague, Senator Moynihan.

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Mr. Chairman, thank you. Indeed, this is a necessary hearing and this is a necessary matter for us to address.

I was pleased to hear you say, as I would expect you to have said, that we are going to be sensitive to those States that have used these monies for the Medicaid purposes intended. There is more than one.

I can say that, in the case of New York, the upper payment limit methodology has enabled us to greatly expand the number of uninsured individuals receiving care. This is a tradition of New York that goes back to the beginning of the last century, and I concede to our distinguished chief of staff that we are still in that century. It is a doctrinal issue of some consequence in this committee.

We want to be careful how we proceed because there are millions of uninsured persons who now are covered because of this payment policy from Medicaid.

I am happy to say, sir, that Dr. Antonia Novello, who is of course the former U.S. Surgeon General and is now the head of the New York State Department of Health, is here in the audience.

I know that she would be more than willing to talk with us and talk with staff about the experience in New York, of which she is, very rightfully, proud and assertive that this is good public health, and I happen to agree with her.

Thank you.

The CHAIRMAN. Senator Breaux.

OPENING STATEMENT OF HON. JOHN BREAUX, A U.S. SENATOR FROM LOUISIANA

Senator BREAUX. Thank you very much, Mr. Chairman and Senator Moynihan, and our panel members who we are going to hear from.

We have a philosophy in Louisiana of, do nothing that is illegal, but do everything that is legal. Lo and behold, my State has found out that this procedure, in fact, is not illegal and, therefore, is legal and has filed an application to do what, apparently, 19 other States currently are doing, and 14 States in addition to mine have applications, in fact, to do.

It is interesting that, when we write these very complicated, and at times too complicated, programs dealing with both Medicare and Medicaid, that if the regulations are printed on Monday, the States, by Tuesday, have figured out what the loopholes are and they take advantage of the loopholes.

I honestly cannot say that I blame them, because what they are, in fact, participating in have been approved by our Federal Government. I mean, these applications to do these types of transfers have been approved in every instance that it is operating in by the Health Care Financing Administration.

So, I do not blame the States for trying to take advantage of what some would call a loophole, and others might say is something that was intended to be allowed, because clearly we in the Congress did not prevent it. I am glad we are taking a look at this.

I think that States, in many cases, have used it, as Senator Moynihan has said, to provide very much-needed services to the poorest of the poor. I have no sympathy for a State that is using it for something else, and apparently there is some indication that some States have used it for purposes other than health care.

But for those States who have taken advantage of what the law says they can do and have used it for the purpose in which it was intended, I cannot say that is bad public policy.

The question is, is it fair? I am sure we are going to hear about that today, and I thank the Chairman for having the hearing.

The CHAIRMAN. Just let me reiterate once again. I can understand why a State might do it, because when the Federal Government fails to issue the regulations correcting it, you could almost say it is an invitation to do otherwise.

But what bothers me, is it is not fair, it is not equitable. I am pleased to hear that much of this is being used to help those that need health care, but at the same time we should be treating all the States alike. Those that did not choose to take advantage of the loophole are put in an impossible position.

So what I want is action, and fairness, and equity, and these funds to be used for the purpose they are intended, for health of the impoverished, not to be exploited for other purposes, which is also the case.

Having said that, there are, what, 31, 32 States either involved in it or getting involved it and it is time that there be action.

Senator Grassley?

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. First of all, the Chairman of the committee has been, in several different capacities—as Chairman of this committee, as Chairman of Governmental Affairs—an outspoken watchdog of waste in a lot of different departments of government, so nobody is going to come here and find fault with the distinguished Chairman, and you are doing that in this regard as well.

On the other hand, I find myself in the exact position that Mr. Breaux has just described for his State. Thinking back about 1 year, Republican State legislators and Democrat State legislators, with just a great deal of enthusiasm, following the suggestion of a Democrat Governor that we have in our State, adopted procedures to pursue this program as Senator Breaux has described.

We were even in the situation of being caught up in helping get approval by the Department of HHS for the particular plan in our State. Now that it is done, then these questions are raised.

So whatever the situation is, people went into this in good faith. I have to raise questions about how a program like this could be around for almost a decade, and now we just come to the conclusion that it is a bad one, where people that oversee this in the departments—presumably 10 years would include some Republicans as well as Democrat cabinet people and presidents—and then Congresses that were controlled by both Republicans and Democrats not coming on top of this before, because if this is as bad as it is made out to be, then we all share some responsibility for not acting sooner.

My legislators would not be trying to create opportunities for the State of Iowa to rob the taxpayers of the United States, because we just are not that type of people. So, consequently, it is very legitimate that we look into this, but I think it is also very legitimate that we not question the motives of people who were involved.

With that, I look forward to getting to the bottom of it, and in the spirit that our Chairman always approaches things of this nature. I thank him for doing that.

The CHAIRMAN. Thank you, Senator Grassley.

Senator Bryan, please.

OPENING STATEMENT OF HON. ROBERT H. BRYAN, A U.S. SENATOR FROM NEVADA

Senator BRYAN. Thank you very much, Mr. Chairman.

I guess I am troubled by what I see here. It seems to me this is kind of like the DSH payment issue revisited. As a former Governor, I have always been inclined to support the maximum flexibility at the State level, having had some experience at that level. But I must say, I think these kinds of abuses tend to undercut my enthusiasm for that kind of an approach.

I will be very anxious, Mr. Chairman, to hear from our distinguished witnesses as to what the States did with the extra money they received. Did all of them use it for Medicaid, was it used for other health care-related purposes, or as we experienced with the DSH payment, something that was totally unrelated to the purpose for which the program is available?

Finally, I must say that it does place those States that did follow the spirit of the law at a disadvantage, and it does, frankly, constitute an increase that is unjustified, in my opinion, in terms of the Federal contribution toward Medicaid.

So I will be very interested in hearing what our witnesses have to say, and I thank you very much, Mr. Chairman, for convening this hearing this morning.

The CHAIRMAN. Thank you, Senator Bryan.

I would now like to turn to our witnesses, and will begin with Michael Mangano, who is with the Office of the Inspector General.

Mr. Mangano, it is a pleasure to have you here. Please proceed.

STATEMENT OF MICHAEL F. MANGANO, PRINCIPAL DEPUTY INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. MANGANO. Thank you, Mr. Chairman and members of the committee.

I am pleased to be here this morning to talk about our ongoing work regarding States' use of what we call manipulative financing techniques that exploit a loophole in the Medicaid upper payment limit regulations.

Specifically, I want to describe how some States are using these intergovernmental transfers to artificially generate excessive Medicaid Federal matching funds for enhanced payments to certain health care providers in their State.

These practices increase the Federal share of Medicaid without a corresponding increase in the States' share, or in the amount or quality of services to the intended Medicaid beneficiaries.

These clever, but we believe unethical, practices are unfairly enriching some States at the expense of others who are abiding by the spirit of the rules.

By way of background, the Medicaid program authorizes Federal grants to States to provide medical assistance to needy beneficiaries. The program is administered by the States and jointly funded, with the Federal matching share ranging anywhere from 50 to 83 percent.

We substantially completed reviews in three States and have work close to completion in three additional States. While there are

slight variations in how these schemes work, there are several basic elements that are common.

All claim to improve the quality of care in nursing homes or hospitals by increasing their Medicaid payment to the level that Medicare would pay for that same service, which is called the upper payment level.

The State then takes, for example, every Medicaid reimbursed nursing home in the State and figures out how much Medicaid would have to pay to raise its reimbursement level to the level that Medicare would be paying. The total amount of funds then becomes the funding pool that is included in their program.

From there, the schemes vary slightly State to State, but probably the easiest way to describe it is to give you an example. I would like to use the example from the State of Pennsylvania.

Instead of giving these enhanced funds that were gotten through a State amendment to their Medicaid plan, the State of Pennsylvania only makes arrangements with county-operated facilities.

The 20 counties that operate 23 nursing homes in that State all borrow the money from the bank and put it into their bank accounts. They then transfer that money in their bank accounts to the State bank account at the same bank.

Within 24 hours, the State reimburses those counties for the total amount of money that they had transferred to them, plus $1.5 million more to pay for what they call program implementation fees.

The counties then pay back their loans, the State then gets the Federal matching share of 54 percent. The State uses the amount from the Federal match to pay some regular Medicaid costs.

We also found that about 21 percent of the money was used for non-Medicaid purposes, and 29 percent was put into a fund that is unbudgeted at the current time. It could be used for Medicaid, it could also not be used for Medicaid. We expect Pennsylvania to generate about $900 million a year in Federal matching funds for what we call these phantom enhanced payments.

The regular Medicaid payment in the 23 county-owned nursing homes in the State average $147 a day. The enhanced payments that are gotten through this mechanism average $426 per beneficiary per day.

Now, you can quite imagine the quality of services that could be provided if they actually got to use that $426. But the sad truth is, the nursing homes never see a penny of it, nor do the other 650 nursing homes in the State that were used to calculate what the total funding pool would be. In some States, enhanced payments are much higher.

Mr. Chairman, in my opinion these schemes are abusive and they erode the confidence of the federal/State partnership that is based on trust.

They are improper for at least five reasons: first, they are unfairly designated solely to generate excessive Medicaid reimbursements without having to meet their State share requirements; second, the vast majority of the so-called enhanced payments are not provided directly to the use that the enhanced payments were developed for, namely the nursing homes in these three States; third, the enhanced payments are not based on the real cost of the serv-

ices; fourth, the Federal funds are ultimately diverted, sometimes to State general revenue accounts and sometimes for non-Medicaid purposes; and finally, when a State uses the returned funds to make Medicaid payments, those Federal funds are then used to generate more Federal funds through the match process.

HCFA has identified 19 States with approved payment plans, and 9 additional States are waiting in line now with new enhanced payment plans.

Based on our work to date, we believe that the widespread use of these State schemes could undermine the stability of the Medicaid program. Our concern is heightened by the fact that HCFA estimates that, even though the number of Medicaid beneficiaries is decreasing nationally, the Federal Medicaid expenditures are increasing by billions due to these schemes. These schemes, we believe, are wrong and the States ought not to do it.

This completes my oral testimony, Mr. Chairman. I would be happy to answer any questions when we get to the appropriate time.

The CHAIRMAN. Thank you, Mr. Mangano.

[The prepared statement of Mr. Mangano appears in the appendix.]

Senator MOYNIHAN. Mr. Chairman, may I congratulate Mr. Mangano on choosing a State which is not represented on the Finance Committee. [Laughter.]

The CHAIRMAN. Let me further congratulate you, Mr. Mangano, because you are discharging the purpose that we had in mind in creating the Inspector General. A lot of times there has been criticism of lack of action and so forth, but I think this is an example of how the system is working and I appreciate that.

The CHAIRMAN. We would, next, like to call upon Kathy Allen, who is with the General Accounting Office. It is a pleasure to welcome you.

STATEMENT OF KATHRYN G. ALLEN, ASSOCIATE DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Ms. ALLEN. Thank you, Mr. Chairman, Senator Moynihan, and other members of the committee. We appreciate the opportunity to be here today to address this very important issue.

In my remarks today, I would like to reinforce some of the points already made by both the Chairman, as well as Mr. Mangano.

Some people consider this a technical and complex issue. Reinforcing certain points may make it easier to understand the significance of the issue.

At the same time, I want to use some examples that add on to the example of Pennsylvania and illustrate just how serious this can be.

As has already been pointed out, Congress has structured the Medicaid program to be a federal/State partnership that provides Federal matching funds. As such, it gives the States considerable flexibility to decide what medical services they will cover, and at what price, as long as certain basic requirements are met.

But our work that has been undertaken at the request of the Chairman indicates that a growing number of States are poten-

tially violating the integrity of this program and are unduly driving up the Federal share of program expenditures.

As has already been alluded to, State attempts to inappropriately maximize Federal payments are not new. Several times in the 1990's reports have surfaced that some States were abusing this Medicaid program flexibility through various financing schemes that increased the Federal share beyond what the partnership agreement calls for.

Left unchecked, the effects of these practices have reached staggering proportions in very short order, as happened in the case of disproportionate share hospitals where payments soared from $1 billion to $17 billion in only 2 years.

In previous years when practices such as these and others have come to light, the Congress and HCFA have been quick to rewrite laws or to take other actions to restrict the practices.

The current financing scheme that distorts this agreed upon sharing of program costs is a variant of previous practices. In fact, it is one that we reported on as early as 1994.

In this practice, States are paying certain providers more than they normally would for the level of services that they actually provide to eligible beneficiaries. The excessive payments are making round trips between the State and the providers.

The State recovers its share of the Medicaid payment and claims the excessive payment as a Medicaid expenditure that generates additional Federal matching funds that the State then spends as it sees fit.

How much this excess payment can be is determined by, again, the upper payment limit. That is, in essence, a ceiling that is put in place based on what Medicare would pay for comparable services for a certain category of providers, such as nursing homes. This is not a price that will be paid, it is merely an upper bound beyond which the cost might be assumed to be unreasonable.

The difference between this upper payment limit and what States would normally pay to Medicaid providers for a certain service is what is being distributed in the excess payment.

The available loophole that States are using channels this payment on a round trip to a very limited number of local government health care facilities, such as county nursing homes, then back to the State.

Now, how this can happen, is that at present States are not limited in how much they may pay local government providers, as they are limited for state-owned providers, as long as the total payments to that provider group, as a whole, including even private providers, fall below the upper limit for the State.

Let me illustrate how this works with a different State example. In 1994, we reported that the State of Michigan determined that it could pay an additional $277 million to county nursing homes and still stay under the State-wide upper payment limit for all nursing homes.

So Michigan made this excessive payment, which included a Federal share of $155 million, to county nursing homes. On the very same day the county facilities received the money, they wired virtually all of it back to the State, retaining only $6 million. None

of these funds were retained to the Federal Government, but were retained to use at the State's discretion.

This practice, which we saw in 1994, prevails today with even more States getting on board. One State plans to make excessive payments to county nursing homes this year that will result in $95 million in additional Federal dollars. Next year, it will be $125 million.

These payments, based on the State-wide upper payment limit, are being channeled through just a few county nursing homes and it is resulting in Federal spending alone of over $900 per Medicaid bed, per day in those few homes; the current Federal payment is $54 per bed, per day.

We have been informed that these funds, upon being returned to the State—they are not staying at the county facilities, they are going back to the State—will be used to create a trust fund that will help pay for assisted living for the elderly, not for nursing home care, which was the stated purpose for the Federal match.

HCFA estimates that more than half of the States now either have plans that allow them to use these practices or have drafted plans for doing so.

Allowing these schemes to continue circumvents the Federal/State funding balance set in law. As we reported earlier, Michigan's practices, for example, increased its Federal matching rate from 56 percent to 68 percent, and reduced State payments by almost $800 million.

Another State's plan, which took effect just last Friday, September 1, will drive its Federal matching share from 50 percent to 62 percent.

To HCFA's credit, it has identified a way to curtail this practice. It has drafted regulations that will limit the excessive payments to local government providers. That is the loophole.

We would urge the administration to finalize these regulations as soon as possible. But the potential for excessive payments continues to persist in, perhaps, other forms.

Consequently, we would suggest that the Congress also consider implementing a recommendation that remains outstanding from our earlier work that would enact legislation to prohibit Medicaid payments that unreasonably exceed the cost to any government-owned facility.

In conclusion, Mr. Chairman, the practices described today take full advantage of technicalities that allow States to supplant State Medicaid dollars with Federal dollars. A remedy is available to curtail this practice, but it must be put in place, and quickly, to avoid any negative consequences from not acting.

But beyond this, we all know that there will be continuing attempts to exploit payment loopholes in the Medicaid program. Therefore, we must always continue to be ever-vigilant to identify the next scheme before it reaches such a magnitude that it becomes a staple of State programs and threatens the integrity of the funding partnership as set in law.

Mr. Chairman, this concludes my prepared remarks.

The CHAIRMAN. Thank you, Ms. Allen. Let me just repeat what I think you said at the beginning, that there are fewer people benefitting from Medicaid, but the cost is going up, partly because of

this kind of scheme, so that it is undermining the stability of the program.

Is that what you are saying?

Ms. ALLEN. That is correct, sir.

The CHAIRMAN. Thank you, Ms. Allen, for your testimony.

[The prepared statement of Ms. Allen appears in the appendix.]

The CHAIRMAN. Now I am pleased to call on you, Mr. Westmoreland.

STATEMENT OF TIM WESTMORELAND, DIRECTOR OF THE CENTER FOR MEDICAID AND STATE OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC

Mr. WESTMORELAND. Thank you, Mr. Chairman, Mr. Moynihan, and distinguished members of the committee.

We appreciate the committee's interest and willingness to join us in ensuring that the Medicaid program retains its mission and its program integrity.

My main messages here today are very similar to the messages I gave the last time I appeared before this committee on school-based services. There are two basic principles that should guide the Medicaid program: first, Medicaid funding is to pay for Medicaid beneficiaries to get Medicaid-covered services from Medicaid-participating providers; second, Medicaid is to be jointly funded by the Federal and State governments.

Whenever anyone departs from these principles without amending the law, however laudable the cause, the Medicaid program itself ends up in trouble. Laudable causes do not justify abusive means.

Please do not misunderstand me: I believe in this program, I support fully and expansively spending Medicaid money for its intended purposes. We have worked to enroll and retain all eligible beneficiaries and to ensure the provision of high-quality services and adequate payment for them. But many of the financing arrangements we are discussing today do not further those goals or those principles.

With those two principles in mind, let me describe to the committee the UPL problem as I have come to understand it. The simplest summary is this. States bill the Federal Government at the Medicare rate, pay Medicaid providers at the much lower Medicaid rate, and use the difference for other purposes.

I became aware of this, oddly enough, through an article in a newspaper entitled The Wichita Eagle on February 19th of this year. Allow me to quote, and I will provide a copy for the record.

"State Sees Windfall in Loophole. Topeka. 'The Federal Government may provide the money to solve the State's budget woes,' Governor Bill Graves said Friday. 'State bureaucrats learned of a little-known Federal program that could provide Kansas with more than $100 million,' Graves said. The money would come from the Health Care Financing Administration, the same agency that runs Medicare and Medicaid.

"The money that Graves wants to tap is usually earmarked by the Federal Government for nursing home care, but an accounting trick used by other States could allow Kansas to send the money

to nursing homes on the condition that they send it back so that the State can spend it elsewhere."

A quick perusal of more newspaper articles from this year also, from one end of the country to the other, led me to find other problems in the States. Allow me, again, to quote from newspaper articles themselves. "A Form of Legalized Money Laundering," "An Accounting Trick," "Windfall," "Medicaid Loophole," and, perhaps most candidly from one State's chief budget officer, "Every time I hear about this I feel like I'm a drug dealer or something."

The clearest, I think, is from one editorial writer.

Senator MOYNIHAN. Is that pharmaceuticals? [Laughter.]

Mr. WESTMORELAND. I would be reluctant to speculate, Mr. Moynihan.

The clearest comes from one editorial writer: "Borrow $20 from a friend, show it to your dad. He gives you $50. Give the $20 back to your friend, and walk away with your wallet $50 fatter.

Now imagine you are the State, your friends are public nursing homes, and your dad is the Federal Government. Talk in millions instead of $20's and $50's, and that, in the most general terms, is how a private consultant is saying the State could save its troubled Medicaid budget."

After a great deal of review, we have found a number of upper payment limit aggregation plans that appear to be problematic. Let me quickly say, they grow from regulations that were adopted as a response to legislative history, beginning in the 1980's, that Medicaid should not pay more than Medicare for similar services.

These regulations were designed for a legitimate purpose, to allow for pooling, to give States the flexibility to pay different providers at different rates because of legitimate factors such as the sickness of the patients, or the acuity of care that is needed, or different wage indices, or rural and urban disparities, and so on.

And, for example, one of the States with upper payment limit plans that we found uses its UPL to pay $14 a day additional to its county nursing home beds, and its county nursing homes are allowed to keep that $14 a day to recognize their increased cost.

Instead, the aggregation has allowed abuses. The oldest and largest of these was approved in 1991. Throughout the 1990's, a few more States proposed such plans and were approved by HCFA for them. I would emphasize that all plans, when they arrive at HCFA, appear to be about health care as they come to us. But after the money that is paid out, is deposited in the State treasury, it is impossible to follow that money and, since money is fungible, to find out what it is used for.

Throughout the 1990's, many of these plans were approved. But since becoming aware of these abusive plans, we have not affirmatively approved any of them. Our counsel advises, however, that they believe the current regulations give us no clear regulatory authority to turn down a UPL plan, and that to get such authority we must amend the regulations through the formal process laid out in the Administrative Procedures Act.

Therefore, HCFA has worked to draft a new regulation. It is a difficult task. We must continue to acknowledge the need for flexibility so that States can reimburse different facilities with different needs differently.

We must also acknowledge that some States have, because HCFA has approved their plans, come to rely on this funding to be available for their budgets. We must also recognize the extreme pressure that public hospitals are under because there are high costs and they are burdened to provide care to people with no health insurance. But we must also limit the abusive spill-over of these regulations.

Since first discovering this, we have also done what Congress has often urged HCFA to do in developing new policies that have a significant effect on the program: we have met with the State Medicaid directors and their association several times, we have briefed the Inspector General and the General Accounting Office and requested their help in reviewing State activities; we have done regulation review with legal, budget, and policy staff; we have had extensive meetings with the National Governors Association, the hospital associations; both general and special interest hospitals such as children's hospitals, the Finance Committee staff itself, the House Commerce Committee, Congressional delegations representing those States who have UPL plans, et cetera.

In July, we sent out a "Dear State Medicaid Director" letter, our document for communicating policy advice, formally announcing, as the Chairman alluded to, our intent to issue an NPRM. I am submitting a copy of that letter for the record as well.

The OIG is now completing its reviews and I hope that we will be able to move soon. We will have a proposed regulation soon. We will, I point out, be issuing this as a notice of proposed rulemaking. We will be requesting comments. We need to assure that this is done deliberatively and correctly so as to survive the inevitable litigation that will follow the issuance of new regulations. We will work to make this regulation as soon as possible.

I need to emphasize to the committee, as some of the members already have, this will be difficult for some States, just as it was when the Congress made provider taxes and donations illegal as a source of State Medicaid funding.

Therefore, it will be necessary to work on transitions for States that have approved State Medicaid plans and that have come to rely on UPL as being a fundamental part of their budgets.

In conclusion, let me say that, with a new regulation, I believe that we can return to working with these two principles: use Medicaid money to pay for Medicaid beneficiaries to get Medicaid services from Medicaid providers, and finance Medicaid jointly between Federal and State governments, with each paying its share.

The Medicaid program has been very successful over the years in providing vital health care services to millions of low-income Americans. It will continue to be successful only to the extent that it adheres to that mission and ensures that the funds provided are used appropriately and that the program retains its integrity.

The program will enjoy public support only if it maintains public trust.

We appreciate the need to proceed with caution in addressing UPL abuses in order to ensure that there is no adverse impact on worthy, but now improperly funded, health care programs. But we also understand the need to act decisively to ensure that the Federal funds are spent in accordance with the law.

I thank you for holding this hearing, and look forward to working with you to preserve that.

That concludes my statement.

[The prepared statement of Mr. Westmoreland appears in the appendix.]

The CHAIRMAN. Well, first, let me, once again, Mr. Westmoreland, congratulate you for the role you have played in helping identify this problem.

But having said that, I am very concerned about the lack of action. The longer we wait, the more difficult it becomes because the more States that are going to be involved.

I think we have already shown very clearly that the States who are not participating are going to feel compelled to do so, that they are losing an opportunity to get funds that every State will feel they can utilize. So, I am very bothered.

Now, I understand the regulation has been drafted and prepared. When are we going to see that action taken? I do not want to say as soon as possible, because that does not, in fact, mean anything. I want to know what day. When can we expect this process to actually begin?

Mr. WESTMORELAND. Well, Mr. Chairman, I am a relative novice in the executive branch of the government, so the wheels of the government grind exceedingly slow, I understand.

We have been working diligently to meet with public hospitals, with States that are affected, with the States that want to be affected, with the States that want to participate. My hope, my fondest hope, is that we will be able to issue these regulations by the end of the month.

I will say, however, that it is an extremely difficult task, as some members of this committee have pointed out. States that have come to rely on this money are telling us that they cannot easily disengage from having this money in their budgets, so the transition period is going to be a difficult thing, with staggered effective dates. It is going to be a difficult thing to create along the way.

The CHAIRMAN. Again, I want to emphasize, action is needed, and action is needed now. I recognized in my opening statement that there are problems in the transition period, but we do not help the situation by delaying corrective action. I cannot stress too much that we ought to move now. This is not something that ought to be pushed off to the next administration, or whatever.

It is improper use of the funds. It reminds me of some of the problems we have with the Tax Code where, when you draft a new regulation, within three weeks the lawyers have 18 exceptions. We cannot wait. I want to make that very clear.

Can you give us a sense of how much this delay in releasing the proposed regulation has cost the program? I understand that HCFA estimates the Federal loss for this year to be at least $2.2 billion, and growing. How much of this cost has been incurred since you first uncovered the problem in May?

Mr. WESTMORELAND. It would be very difficult to put an easy assessment on how much money is at stake that has been changing since the time that the problem was unveiled. Many States submit there are aggregate upper payment limit plans to the Medicaid program as a provision that they reserve the right to build the Federal

Government up to the Medicare upper payment limit, but do not actually tell us how much they intend to pay until the end of the quarter or until the end of the fiscal year.

We believe that, as you say, over $2 billion, maybe more, is attributable to new increases. Those may be existing State plans or they may be plans lapsing into approval during this time. We believe that we can identify at least $2 billion over the State estimates for fiscal 2000 that they made for us a year ago.

But it would be an error for me to try to annualize that, because States come to the Federal Government with an estimate for a quarter that may be lasting a full fiscal year, or they may come for the full fiscal year, or they may show us only the additive estimate. It is, in many ways, impossible to estimate the dollar value or the dollar cost to the Federal Government until after the books are closed at the end of the year. I am sorry.

The CHAIRMAN. Let me ask you this question that is very bothersome to me. Why does HCFA believe it cannot deny the approval of State plan amendments that are used to perpetuate these financing schemes when it is so obvious that the funds, in many cases, are not being spent on legitimate Medicaid services and beneficiaries? Why can you not take action now?

Mr. MANGANO. Mr. Chairman, the regulations, as my colleagues on the panel have pointed out, laying out how to arrange aggregation of upper payment limit are exquisitely detailed.

My counsel advised me that, if we are to make changes in the way that we have approved States to do this in the past, without appearing to be arbitrary and capricious, that we need to proceed through the formal rulemaking process of the Administrative Procedures Act. That is their best judgment for me now.

Proceeding through the Administrative Procedures Act is the best way of surviving the ultimate litigation that is going to come as a result of this. Some States have told me that they would be willing to sue over the amount of money that is at stake here.

So, if I may, I would say that in order to do this right and in order to have the regulations stick as opposed to falling in court, we need to go through the formal APA process rather than simply acting on an ad hoc basis. Acting on an ad hoc basis may be viewed by some courts as arbitrary and capricious.

Now, let me also say to the committee why that is most important here. If we were to lose a regulation in court as not being in compliance with the Administrative Procedures Act, whatever procedural defect there may have been in the process, States would be entitled to claim all the way back to the beginning of the fiscal year in which they first filed their State plan amendment. So, if we lose, we would lose all of that money, too. So in the long run, doing it deliberatively and through the formal process of the APA, it is more likely to survive than doing it in the short run on an ad hoc basis.

The CHAIRMAN. Well, as I listen, it seems to me that you are only underscoring the importance of taking action to correct the regulations, and we cannot delay that.

Let me turn to Mr. Mangano. In your testimony, you state that you believe the widespread implementation by States of the manipulation of the upper payment limit could undermine the stability

of the Medicaid program. Now, those are strong words. Please tell me exactly what you mean.

Mr. MANGANO. Let me go back to the example that you raised a little earlier about the disproportionate share and taxation and donation program, because our office was involved in auditing States with regard to that issue back in the late 1980's.

When we issued our public report, within 8 months of our issuing the report the number of States who jumped into that loophole went from 14 to 30, and the amount of money in the first year that was lost to that went from a half a billion to $4 billion; more and more States were jumping on the bandwagon.

The States that are already in this program, are already using this loophole, have other opportunities, even in themselves, to increase the amount of money they are getting from the Medicaid program.

The example I used of Pennsylvania was only with nursing homes. If they should choose to do this with hospitals, clinics, intermediate care facilities for the mentally retarded, they could quadruple the amount of money that they are drawing down.

Pennsylvania is drawing down $900 million a year right now. So if you think about what is open to just that one State, we are talking close to $4 billion just on that one particular issue area.

So the 19 States that have plans right now do not cover all the possibilities that they could cover. So when you start to multiply that out by 50 States and all the opportunities, this thing could open up very wide and then the Congress would be put in a position of deciding, how large do you want the Federal share of Medicaid to be?

The CHAIRMAN. Does the Office of Inspector General believe that HCFA should move immediately to close down this loophole?

Mr. MANGANO. Absolutely. Mr. Westmoreland is absolutely right, we have got to move as quickly as we possibly can to close it down.

I did offer one other option in the testimony, and that was for the Congress to act. HCFA has to deal with the law as it is. If the Congress should choose to change the law and close off this loophole, then it could be changed more immediately.

The CHAIRMAN. Ms. Allen, let me turn to you. Can you provide us with specific examples of how States use the increased Federal Medicaid payments they receive through this loophole?

Ms. ALLEN. Mr. Chairman, as we have looked into these practices, we find that sometimes States are quite explicit and open in their documentation, either in their State Medicaid plan amendment, or even in correspondence with HCFA, in terms of what they plan to do.

In my written statement, there is a table that provides some very concrete examples of where States are very explicit about what they plan to do. I am not sure the term has been used today, but there is the term of intergovernmental transfers, where the money is being channeled from the State to the local governments and back.

For example, we provide an example where one plan specifies that these excessive payments made to the local providers will be subject to a minimum of 82 percent to be transferred back to the

State treasurer. So, sometimes it is very explicit about the round trip that the money will be making.

Sometimes it is less explicit about how exactly the money will be used, but occasionally, either in talking with State officials or even looking at correspondence, they are quite open about some of their intended purposes.

One example that I mentioned earlier would be to help fund a trust fund that would help convert excess nursing home beds to assisted living facilities. There is other evidence that perhaps the supplemental money will be used for mental health care for State correction facilities, building of veterans nursing homes. It is really quite surprising at how explicit they are in some cases.

The CHAIRMAN. Let me point out that we have confronted similar funding scams in the Medicaid program in the past. Why have our past actions not been sufficient to prevent this new exploitation from taking place?

Ms. ALLEN. Mr. Chairman, the earlier practices and this one have one thing in common. It is the round trip of money between the State and local providers. Congress has acted on several occasions in the 1990's to reduce or limit some of these practices. Provider taxes and donations is one example, disproportionate share hospital payments is another example.

What is unique about this, is that an action that HCFA took, actually back in 1987, to establish a separate upper payment limit for State-operated facilities, stopped short of addressing this issue.

State-operated facilities were doing this in the 1980's, so a limit was put on State-operated facilities, which went a long way to at least curtail the magnitude of this practice.

The current loophole is that there is no upper payment limit for local government providers, and this is what this regulation would do. I would add, though, while this would help curtail this practice, it does not take care of the problem altogether, which is why we suggested that the Congress may still wish to consider an earlier recommendation that would look at the price that is being paid for services.

Perhaps the Medicare upper payment limit is not exactly the right mechanism to use. It has served us well to date, but perhaps it is time to begin to look at a different criteria or ceiling to determine what reasonable costs actually are.

The CHAIRMAN. Well, I think that is a reasonable assumption and something worth looking at. I think we all recognize, as a practical matter, in the next five weeks we are not going to have that kind of opportunity to make those kind of hearings and objective analysis. So I am sympathetic to what you and Mr. Mangano have to say, but that would entail something much larger.

The thing that really bothers me, Mr. Westmoreland, and this is not directed at you personally, that HCFA cannot stop this situation without a regulation; that it is believed by all of you that a regulation would correct it, but the regulation has not yet been issued since the problem was discovered in May.

We do not know exactly how much the delay is costing us, and no one can tell us when the beginning of the regulatory process will begin. It seems to me that it ought to be very simple for the administration, for HCFA, to start that process now.

We are all sympathetic and understand that problems will occur that have to be worked out, but the longer we delay the broader the problem becomes and the more difficult it becomes to resolve.

Mr. WESTMORELAND. If I may, Mr. Chairman. Certainly I agree that we need to close the loophole, and I think the administration agrees with that. If I could, I would say that the fairly exhaustive consultation that we have done in advance of issuing a regulation will allow us, I believe, to have a very short comment period. The typical comment period in the Administrative Procedures Act is usually 60 to 90 days. For this regulation, we intend to have a 30-day comment period, which is, I think, the shortest allowed by the APA.

So I am hoping that the advance consultation will have shown us some of the problems that States and public hospitals will encounter as we attempt to change the aggregate upper payment limit regulation and will allow us to have an abridged comment period so perhaps we can make up for lost time.

The CHAIRMAN. Senator Moynihan?

Senator MOYNIHAN. Thank you, Mr. Chairman. Thank our witnesses for their clarity and succinctness.

I have to allow that I am in a bit of an anecdotal mood. I have been on this committee, a quarter century or near thereto, and I remember the first commencement address I gave as a member of the Finance Committee at Kingsboro Community College in Brooklyn, Brookings County.

I raised the issue of the Medicaid formula, in which the Federal matching rate ranged from 50 percent to 83 percent. It was really quite extraordinary. The formula involves taking the square of the ratio of a State's per capita income to the national per capita income. I proposed then and there, and the New York Times, I am afraid, did not report this—[Laughter.]—that, instead of the square of the ratio we use the square root. It seems to me, elemental.

Why not change every half century or so? Nothing has changed, not a word. Mr. Westmoreland, it is not your doing, but no administration, this administration included, has ever suggested touching that formula, which our beloved former Chairman from Louisiana, Mr. Russell Long, once said, is the South's revenge for the Civil War. [Laughter.] I do not doubt that some revenge was in order.

So we are dealing here with the fact that some States, who are absolutely disadvantaged by the basic legislative formula, have sought other means to pursue the purposes they have committed to for most of the century, as New York State has done: health care for the indigent.

I have a letter to the President here from some dozen members of the House, bipartisan, Rick Lazio, Tom Reynolds, Amo Houghton, John McHugh, saying that if this were to change, it would devastate the delivery of health care in New York. Devastate is a word not to be used lightly.

So I would like to ask Mr. Mangano, Ms. Allen, and Mr. Westmoreland, one issue. Are you going to examine the impact that a dramatic change in the upper payment limit regulations would have on access to health care for low-income individuals and on quality of care in nursing homes in affected States?

Are you going to think about what will happen when you send out your proposed ruling, this 30-day period under the Administrative Procedures Act? Mr. Mangano, please.

Mr. MANGANO. Our audits will not go to that issue in specific, but I can tell you some things. That is, that in the States that we have looked at with regard to Pennsylvania, for example, none of the money that the State gets from the Federal Government is given to that nursing home as additional funding.

Senator MOYNIHAN. So what about New York?

Mr. MANGANO. We have not done New York.

Senator MOYNIHAN. Well, could I ask that you do it? With greatest respect, may I insist that you do it? Medicaid is to help poor people with health care.

Mr. MANGANO. Right.

Senator MOYNIHAN. New York has a special situation. I do not think any other State is quite like it. Forty percent of the population in New York City is foreign-born, the highest level since 1910. Some of these people are well-to-do professionals; most are not.

That situation, which gave rise to the social programs first of the administration of Alfred E. Smith and Robert Wagner, was conveyed to Washington by Frances Perkins and Franklin Roosevelt.

Ms. Allen?

Ms. ALLEN. Our current work also, to this point, has not directly assessed the impact on access to quality care. But we should emphasize——

Senator MOYNIHAN. It does not even have to be quality care, just access to care.

Ms. ALLEN. Just care. There is no argument that, if these Medicaid dollars were being spent on eligible beneficiaries, there would be no issue.

Senator MOYNIHAN. So if in New York they are, there is no issue.

Ms. ALLEN. There is no issue if—if—the funds which the State is requesting are being spent for those purposes.

Senator MOYNIHAN. Good. Now, General Westmoreland? [Laughter.] Got that? Agreed? All right, sir.

Mr. WESTMORELAND. First, Mr. Moynihan, I should apologize, I am remiss in owing you a letter that I promised the last time I was here describing the square root and the cube roots and the algebra that we talked about the last time.

I have such a letter, including many things that I think can only be called some amalgamation of a bad story problem from high school algebra and what I call forensic calculus. So I, first, promise to get that letter to you, even though I promised it the last time I was here.

Senator MOYNIHAN. Before January 3, please. [Laughter.]

Mr. WESTMORELAND. Yes, sir. Well, I had understood you were going to use it for your post-employment work in the Senate, that you were going to be writing on forensic calculus here.

But having said that, I think there is an important point to be made here of, if I may, a distinction that was blurred, which is the difference between poor people and Medicaid-eligible people.

The Congress has insisted in many ways that Medicaid remain a very limited program for categorically eligible poor people. It is

not available to all poor people in America. While some of us may think that Medicaid should be available to all poor people without link to categorical assistance or to categorical eligibility, it is not. So to the extent that Ms. Allen is saying that there should be no problem if it is used for Medicaid-eligible beneficiaries, I certainly concur.

To the extent that the distinction is blurred between, simply, poor people and not people who are Medicaid-eligible, I have taken an oath to support a statute, not a concept. The statute says that people are to be eligible.

Some States, as you certainly know in the TANF delinking process and others, have been calculating to excruciating detail that if someone has $1.25 too much in annual income or has one pay stub missing, they are not eligible.

Senator MOYNIHAN. Peace. Peace, sir. My time has run out. I do not disagree. But these are two categories. Let us put some quantities on both.

Mr. WESTMORELAND. Yes, sir.

Senator MOYNIHAN. Thank you very much. Thank you all.

The CHAIRMAN. Senator Grassley?

Senator GRASSLEY. I have no questions.

The CHAIRMAN. Senator Breaux?

Senator BREAUX. Thank you, Mr. Chairman. Thank the panel for their statements.

I have heard these programs that the States are engaged in described, I think Ms. Allen said financial schemes; Mr. Mangano, you were quoted as calling it "legalized money laundering."

Is it not correct, Mr. Westmoreland, that of the 19 States that are engaged in this right now, that every single one of those States submitted an application to HCFA which I presume was carefully reviewed, and I presume was then approved by HCFA who told the States, go ahead and do what you have submitted to us. Is that not correct?

Mr. WESTMORELAND. With one minor correction, sir. Of the 19 States, 14 have been approved by HCFA affirmatively.

Senator BREAUX. All right. Let us deal with the 14 then.

Mr. WESTMORELAND. Yes, sir.

Senator BREAUX. Are the 14 engaged in legal money laundering and financial schemes, and if they are, is it not a fact that HCFA has, in fact, approved those financial schemes and legalized money laundering?

Mr. WESTMORELAND. Yes, sir.

Senator MOYNIHAN. Would you care to elaborate? [Laughter.]

Senator BREAUX. Well, I think that if it goes back to 1991, 1992, I think Pennsylvania was the first one to come in. Why has it taken 8 years for somebody to recognize this as being legalized money laundering and proposed regulations to change it?

Mr. WESTMORELAND. First, I would say that I cannot speak to that, since I am a relatively new arrival. But, having said that, I would say that it is my belief that there were fewer of these plans at the beginning of the process, only a handful, and the people at HCFA did not recognize the extent to which the abuses could enlarge.

Many of these plans are submitted to us in a way that read that the States reserve the right to pay up to the Medicare rate, which is explicitly what our regulations allow, and we do not follow the money after it is deposited in the State treasury. That is not the custom, to find out where the money goes afterwards.

Senator BREAUX. Have any of the 14 States that have been approved by HCFA been found to be doing something that was outside the scope of the plan that HCFA approved?

Mr. WESTMORELAND. No, sir, not to my knowledge. Mr. Mangano has been doing——

Senator BREAUX. The disturbing thing that I have here, is that we are emphasizing the States doing these schemes and legal money laundering, and yet we in Washington, probably with the help of a number of members of Congress, have written, called, and supported this effort and now have it sort of made to look like the States are doing something that was highly inappropriate and improper. But yet, every State that is doing it has been approved by the Federal Government that runs the program.

Mr. WESTMORELAND. Mr. Breaux, I do not mean to suggest that States are doing anything illegal in any way. These have been approved and I do recognize that.

Senator BREAUX. Well, Ms. Allen and Mr. Mangano talked in terms of legalized money laundering and financial schemes. That does not sound too complimentary to what they are doing. If I was from the State I would say, look, I have got this piece of paper from Washington that says I can do exactly what I am doing, and now you are calling it all kinds of dastardly names.

Mr. WESTMORELAND. With all deference, I think the important word in that phrase is legalized money laundering. I do consider this to be inappropriate, but it is not illegal.

Senator BREAUX. Well, how can it be inappropriate if your office has stamped its approval on it?

Mr. WESTMORELAND. I am afraid that, in retrospect, I think people would have been better advised to propose a more limited regulation that did to other publicly-owned facilities what we did in 1987 for State-owned facilities. I think it would have been better advised.

Senator BREAUX. I mean, I think this point has been made very clearly.

The last point, the only other point, is I want to know what happens to the 14 States that have pending applications, and my own State is one of them, in which you have met with them, I have asked you to meet with them.

I want them to do as I have said, do everything that is legal and do nothing that is illegal. So what happens to the 14 States, under the current regulations that have pending applications?

Mr. WESTMORELAND. If those States reach their statutory period, HCFA essentially has 180 days to say yes or no to a State. If we do not say no, then the application is deemed to be approved by the function of Social Security.

Senator BREAUX. So it is possible then that some, if not all, of these 14 that have pending applications under the current regulations will, in fact, be approved before the new regulations outlawing this practice become final?

Mr. WESTMORELAND. A large portion of them may become deemed approved. It would be our intention, after the regulation becomes final, to begin compliance actions and bring those State plans into compliance with the new regulations.

Senator BREAUX. All right. So in a couple of months we could approve them, and then in a couple of more months we will take action against them for what we have approved and allowed them to do.

Mr. WESTMORELAND. I do draw a distinction here between approving them and allowing the statute to take its function. We have not affirmatively approved these.

Senator BREAUX. But the end result is the same.

Mr. WESTMORELAND. Yes.

Senator BREAUX. I mean, the irony of this is we are going to be letting States, allowing States, to do something in the next couple of months, possibly, that in the next couple of months after that we are going to be taking action against them to disapprove what, in effect, we have allowed them to do.

Mr. WESTMORELAND. Yes. And in the cases of those five States that have then lapsed into approval, I have in each case told the State Medicaid director, or in one case the Governor, that they should not depend on this money being there in the future and should not come to rely on it.

Senator BREAUX. So it is sort of like "buyer, beware."

Mr. WESTMORELAND. It is. In many ways, it is the legal concept of reasonable reliance. States that have affirmatively approved plans, I think, have reasonably relied on HCFA that money will be there. The States that have lapsed into approval or will lapse into approval, I am asking not to come to rely on this money to be available in the future.

Senator BREAUX. What an interesting predicament we have weaved for ourselves.

Mr. WESTMORELAND. We have.

Senator BREAUX. Thank you very much, Mr. Chairman.

The CHAIRMAN. Is it any wonder that the American taxpayer is cynical? They are not alone.

Senator Bryan, please.

Senator BRYAN. Thank you very much, Mr. Chairman.

Mr. Westmoreland, I think you used an estimate of $2 billion annually, is the cost to this. I would be reluctant to pin a cost annually on it. It is a $2 billion increase in this year over baseline.

Senator BRYAN. A $2 billion increase. And you attribute that to the inappropriate use of this mechanism which we have discussed this morning?

Mr. WESTMORELAND. I attribute it to rises on the upper payment limit. It is not clear to me that all of them are inappropriate, so it may be small.

Senator BRYAN. Any estimate, if you fail to take action, as to what the magnitude of the expense would be if all of these plans that are pending are approved? Frankly, if you take no action, a State would be foolish not to take advantage of this provision. I would think every State would apply. What is the range of increase we might expect?

Mr. WESTMORELAND. I would be reluctant to guess at that today. I can try to supply that for the record if you wish.

Senator BRYAN. I would take it it would be many, many billions, would it not?

Mr. WESTMORELAND. Yes, sir. I think, in my prepared testimony, I have suggested that if the problem is not solved it will go to the tens of billions.

Senator BRYAN. Tens of billions of dollars. As Senator Dirksen used to say, "A billion here and a billion there, before long we are going to be talking about real money." So, this is not an inconsequential problem.

I must say I am somewhat perplexed. You have been advised legally that taking the example that Mr. Mangano has given of the State of Pennsylvania, that that is, although inappropriate, we have used various terms to characterize it, but nevertheless that is legal under the existing regulation?

Mr. WESTMORELAND. Because Pennsylvania estimates how much would have been paid had Medicare been paying the bill and then aggregates that and sends that to us for a matching payment, yes, sir. That is explicitly what our regulation outlines.

Now, I do not mean to say that, on further review, Mr. Mangano, Ms. Allen, or others might come to a different conclusion. Since our regulation explicitly lays it out, I am advised that we would be better advised, and hope to have it stick, to go through the Administrative Procedures Act.

Senator BRYAN. Better is different than saying that it is legally permissible.

Mr. WESTMORELAND. I did not mean to split the hair.

Senator BRYAN. Yes. I guess if we had a piece of legislation that might be better than a regulation, because in the hierarchical scheme of things, a legislative enactment might be deemed as being more significant than a regulation which you all can impose.

You are saying now that you are going to get this regulation, as you hope, on line by the end of this month, and we are talking about September.

Mr. WESTMORELAND. Yes, sir, as a proposed regulation.

Senator BRYAN. All right. This practice has been going on for eight or 9 years.

Mr. WESTMORELAND. The earliest aggregation plan that I can find was approved in 1991.

Senator BRYAN. But when did the agency first become aware of the abuse?

Mr. WESTMORELAND. The extensive abuse started showing up in just this calendar year as more and more States started to propose upper payment limit plans.

Senator BRYAN. Mr. Westmoreland, what troubles me about that, it seems to be saying that, look, if this abuse was, say, only a half a billion dollars, nobody would get much heartburn about that. That would be all right. But now that it has reached this critical threshold of $1 billion, or several billion, all of a sudden we get energized.

It strikes me that that is not a very comforting distinction to make to the American public. I mean, most people would think mil-

lions would be a lot of money. Why was no action taken even when the abuse was not as recognized as being as widespread as it is?

Mr. WESTMORELAND. I think I would say that, in 20/20 hindsight, it is clear that there were problems and that people would have been better advised to do other public facilities in the same way that we did States.

Senator BRYAN. You do not really have to have Promethean vision to see that if one State is going to get away with this, other States could be encouraged to do so.

Mr. Mangano, a question to you, sir. I have a little difficulty, and Senator Moynihan, our Ranking Member, was asking that if all of this money goes into Medicaid, then there is no problem.

Now, where you say, for example, in the State of Pennsylvania, which you have cited as a case in point of abuse, if all of that additional money that they received through this mechanism is all used for Medicaid patients, then the abuse is cured?

Mr. MANGANO. Let me just give you some facts from the State of Pennsylvania. The State of Pennsylvania, in the last 3 years, brought in $1.9 billion as the Federal match to it.

Senator BRYAN. And how much of that was in excess of what should have been brought in, in your view.

Mr. MANGANO. In my view, all of it.

Senator BRYAN. All of it. So $1.9 billion is based upon this loophole in the law, let us characterize it.

Mr. MANGANO. Correct. That is correct.

Senator BRYAN. All right.

Mr. MANGANO. Now, of that $1.9 billion, to the best of our understanding, about half of that was used by the State as the State's regular Medicaid expenditures. When they did that, and that is just under $1 billion, they then matched for another $1.3 billion in Federal matching money.

About 21 percent of that money—it was about $400,000—was put to use in non-Medicaid and non-Federal programs. It was used for State welfare and health programs, not a Federal match.

Senator BRYAN. So that would be an inappropriate purpose under the law.

Mr. MANGANO. Absolutely.

Senator BRYAN. Desirable socially, something that we would probably approve of in principal, but not consistent with the law.

Mr. MANGANO. Right. Right. Correct.

Senator BRYAN. All right.

Mr. MANGANO. Twenty-nine percent of the money was put into another fund that would fund either Medicaid services or non-Medicaid services, so at least a portion of that money would have been put to that use.

Senator BRYAN. All right.

Mr. MANGANO. In another State that we looked at——

Senator BRYAN. But let me ask you.

Mr. MANGANO. Sure.

Senator BRYAN. But all a State would have to do to cure this would be to say, look, rather than putting it into long term care, or something, we are going to all devote this to Medicaid patients?

Mr. MANGANO. That would not be my view.

Senator BRYAN. That would not be your view.

Do you disagree with that, Ms. Allen? I thought I understood you saying, in all deference to our distinguished Ranking Member, that that would cure the problem. Maybe I misunderstood the Senator from New York's question.

Ms. ALLEN. There is a distinction to be made here in terms of——

Senator BRYAN. Help us to understand it, if you will, Ms. Allen. I am not sure that I am following.

Ms. ALLEN. I have been chomping at the bit here.

Senator BRYAN. Good, you are chomping. Well, ride that horse. All right.

Ms. ALLEN. Even if certain services are covered services for eligible Medicaid beneficiaries, it might be for different services other than for what this methodology is intended to pay.

Let me just take an example. The upper payment limits that are approved by HCFA are explicitly for inpatient hospitals, outpatient hospitals, skilled nursing facilities, intermediate care facilities for the mentally retarded.

The assumption is that, when the increased payments are being approved for those services at those amounts, that that money will be going to pay for those services. But that is not what is happening.

Senator BRYAN. I think we understand that. But I guess my question is, and I know that I am over my time, but if I can just finish, you are saying that if all of the increased money, the money that is deemed to be inappropriate, is dedicated to those categories, if I understand, then that would, in effect, cure the defect or the abuse.

Ms. ALLEN. If they were going back to those same facilities for which the methodology was approved.

Senator BRYAN. Sure. All right.

Ms. ALLEN. But if I could please comment on one other point, which is about HCFA's approval of the plans and why it appears, on one level, to be valid approvals.

The issue here is that the States are saying, we have made expenditures to certain providers for certain services, therefore, here is our claim for payment. It comports with the methodology that was approved.

The problem though, is that there is an intergovernmental transfer of funds whereby those funds were not spent for the intended purposes. The difficulty is that HCFA does not really have the authority to go and question what is happening on the ground level, and that is what we believe needs to be assessed.

Medicaid payments are to be provided for care and services that are consistent with efficiency, economy, and quality of care. The situation where, for example, the Federal Medicaid payment is increasing from $54 a day to over $900 per bed, per day in a facility, that is not, in our estimation, consistent with these criteria.

Senator BRYAN. I guess, Ms. Allen, the point that whatever changes are going to be made, they do have to allow flexibility that some States may have a different situation than other States, assuming all of the money is legitimately dedicated to the purpose for which it was intended.

I guess what I am having difficulty with, and I know I have passed my time, Mr. Chairman, and I will forbear, but I am having some difficulty understanding the comments that were made earlier, that if you simply used all of this money for Medicaid, then we eliminate the so-called abuse, and the distinction, I think, that Mr. Mangano and others have made where that may not be the case.

So perhaps we could pursue that at a later time, Mr. Chairman, so that I could get some clarification and understanding. I may be the only member of the committee that is not completely clear on that.

I understand you should not be using it for non-Medicaid purposes. That is very clear. But if you are using it for an enhanced Medicaid benefit, I am not sure whether that violates the spirit of the law or not.

I thank the Chairman, and I thank our very distinguished panel.

The CHAIRMAN. I thank you, Senator Bryan.

I understand, Senator Moynihan, you may have one other question.

Senator MOYNIHAN. A quick, final question which follows on the inquiries of my colleague from Nevada.

First of all, same obiter dicta. How is that? Have you got that?

Mr. WESTMORELAND. Very good. There is a career after life in the Senate for you, sir. Very, very good. [Laughter.]

Senator MOYNIHAN. New York's use of this funding mechanism; HCFA approved it in 1995.

Mr. WESTMORELAND. Yes, sir.

Senator MOYNIHAN. Now, under the common law, does a common law right not emerge from such long and settled usage? Do not answer, but check with your counsel, would you? [Laughter.] I would just make that point.

But the question I would like to ask, Mr. Chairman, and I think we do need to know, is what is Medicaid-eligible today? In 1965 when we passed the legislation it was very simple: if you received Aid to Families With Dependent Children, you were eligible for Medicaid. It was clear.

Well, in 1996, we abolished Aid to Families With Dependent Children, so what is the current criteria?

Mr. WESTMORELAND. The first thing I would say, is even though the Congress chose to abolish Aid to Families With Dependent Children, the eligibility for those same families was retained by the Congress.

So even though people lose their individual entitlement to Temporary Assistance for Needy Families, in its new name, they retained their Medicaid eligibility.

Senator MOYNIHAN. But that is a grandfathering.

Mr. WESTMORELAND. No, it is not grandfathered to the individuals. Even though it is no longer used for AFDC, people who meet the criteria——

Senator MOYNIHAN. Yes. But what about new families coming along?

Mr. WESTMORELAND. Many new families are eligible under Section 1931.

Senator MOYNIHAN. Could you just give us a piece of paper on that?

Mr. WESTMORELAND. Yes, sir.

Senator MOYNIHAN. I think we do need it, Mr. Chairman.

Mr. WESTMORELAND. Yes, sir.

[The information requested appears in the appendix.]

Senator MOYNIHAN. Thank you very much. You are a wonderful panel. How tough are the bar exams in Nevada? [Laughter.]

Mr. WESTMORELAND. I think, based upon the Ranking Member's colloquy, I think we could get a waiver without any difficulty at all. [Laughter.]

Senator MOYNIHAN. Thank you, Mr. Chairman.

The CHAIRMAN. As I recall, that was a Senator Chafee initiative, to ensure that those individuals continued.

Mr. WESTMORELAND. Yes, sir.

Senator MOYNIHAN. Typical of John Chafee.

The CHAIRMAN. I want to thank the panel. I think all three of you have been very helpful. My concern, is the statement that you made that if this is not corrected, it could put at risk the entire program, and Medicaid is an important program that we all support and want to ensure that it is being administered in an appropriate fashion.

So I thank you for being here today, and we will continue. But I do urge, let us take action now.

Mr. WESTMORELAND. Thank you, sir.

The CHAIRMAN. The committee is in recess.

[Whereupon, at 11:28 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

United States General Accounting Office

GAO

Testimony

Before the Committee on Finance, U.S. Senate

For Release on Delivery
Expected at 10:00 a.m.
Wednesday,
September 6, 2000

MEDICAID

State Financing Schemes Again Drive Up Federal Payments

Statement of Kathryn G. Allen, Associate Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division

Mr. Chairman and Members of the Committee:

We are pleased to be here today as you discuss the federal government's role in helping pay for Medicaid. The Congress has structured Medicaid as a federal/state partnership that provides federal matching funds and gives states considerable flexibility in deciding what medical services and individuals to cover, as long as certain basic requirements are met. Over the years, the Congress has also attempted to make the program easier for states to administer and to provide more flexibility in how they may distribute funds to Medicaid providers. However, several times in the 1990s reports surfaced that some states were abusing this flexibility through various financing schemes that increased the federal share of program costs beyond what the partnership agreement calls for. When these practices came to light, laws or regulations were rewritten to stop or restrict them. Now there are reports that a number of states are engaging in a practice that is a variant of previous practices. Limiting this practice would involve taking similar action to what has been done in the past.

In my testimony today, I will (1) describe how this current financing scheme works and (2) discuss how it compromises the agreement for federal/state sharing of Medicaid financing. We have reviewed state plans describing this financing arrangement and have discussed the issue with officials of the Health Care Financing Administration (HCFA) and other agencies. We have not yet identified the extent to which these schemes have been implemented or the amount of money involved, but at the request of the Committee, we will be continuing our work in this regard. Because this scheme is so similar to some practiced previously, I will also draw on our prior work.[1]

In brief, the current scheme inappropriately increases federal Medicaid payments by paying certain providers more than they would normally receive and then having the providers return the bulk of the extra monies to the state. By making an excess payment, the state generates additional federal matching funds, which can be used to pay its share of future Medicaid payments—thus generating even more federal matching funds—or spent however the state determines. The providers receiving the inflated payments and passing back the excess to the state are entities owned by local governments—for example, county-owned nursing homes and local hospital districts. According to HCFA, as of late July, 17 states have state plans that could allow them to use this practice, and 11 other states have drafted plans for doing so. The exact amount of additional federal Medicaid dollars generated through this process is unknown, but it is in the billions of dollars and growing. While most states do not specifically acknowledge how they will use the money that makes the round-trip back to their treasuries, intended uses reported by elected officials in some states include funding other health-care or education programs, as well as subsidizing a state tax cut.

In our view, this financing practice violates the integrity of Medicaid's federal/state partnership. By receiving part of the money back from the provider and keeping the federal share associated with it, the state is—in effect—able to lower its own Medicaid contribution substantially below the share specified in federal law. We have not yet been

[1]See the list of related GAO products at the end of this statement.

able to specifically determine how much of an effect this current practice will have in any one state. However, our analysis of previous financing schemes showed that the effect can be substantial. For example, in 1994 we analyzed Michigan's use of similar funding mechanisms (including excessive payments to county nursing homes) and found they had the effect of raising the federal share for Medicaid expenditures from 56 percent to 68 percent. When related schemes came to light in years past, steps were taken to curtail them and restore the federal/state partnership as intended. HCFA has drafted a regulation that would curtail this scheme, but the draft has not moved far in the rulemaking process. We urge the Administration to finalize this regulation and reiterate a recommendation to the Congress, first made in 1994, that would close the door on financing practices that inflate the federal share by making excessive payments to government-owned facilities.

BACKGROUND

The federal and state governments' shares in the cost of Medicaid are based on a statutory formula designed to reflect differences in each state's program needs and capacity to finance them. At a minimum, the federal government pays 50 percent of the cost. However, poorer states—those with a low per capita income—receive federal contributions at a higher matching rate. The aim is to reduce differences among the states in medical care coverage for the poor and distribute fairly the burden of financing program benefits among the states. Under this statutory formula, the federal payment for the poorest states can be up to 83 percent of the program's cost.

Within a broad legal framework, each state designs and administers its own Medicaid program, including deciding how much to pay providers for a particular service. Each state operates its program under a plan that HCFA must approve for compliance with current federal law and regulations. In addition, HCFA must approve any amendments to this plan.

To control federal expenditures, HCFA established a set of upper payment limits on the total amount it would agree to pay states for a variety of services. For example, one upper payment limit sets a maximum amount of federal payments for all nursing homes in a state.[2] The upper limits are based on the payment amount allowed under the Medicare program, which is the federal government's program for providing medical services for the elderly and the disabled. The upper limit is not a price to be paid for each service provided, but rather a ceiling on Medicaid expenses above which the federal government will not share.

The flexibility states have to set Medicaid's payment rates has provided them the opportunity to develop various financing schemes in the past that effectively changed what the federal government paid (see table 1). Most of these financing schemes have subsequently been restricted by law or regulation. While such restrictions curtailed the

[2]Upper payment limits currently exist for different classes of services, including inpatient hospital services, outpatient hospital services, nursing facility services, and intermediate care services for the mentally retarded. Separate upper payment limits are set for state-operated facilities that provide each of these services, with the exception of outpatient hospital services, which have no upper payment limit.

specific schemes that had been brought to light, the restrictions did not extend to transactions with certain government health care providers, such as local- and county-level providers. To address this problem, in 1994 we recommended that the Congress enact legislation to prohibit Medicaid payments that exceed costs to any government-owned facility. That recommendation remains outstanding.

Table 1: Examples of Previous Medicaid Financing Schemes for Generating Federal Funds Without Committing a Corresponding State Contribution

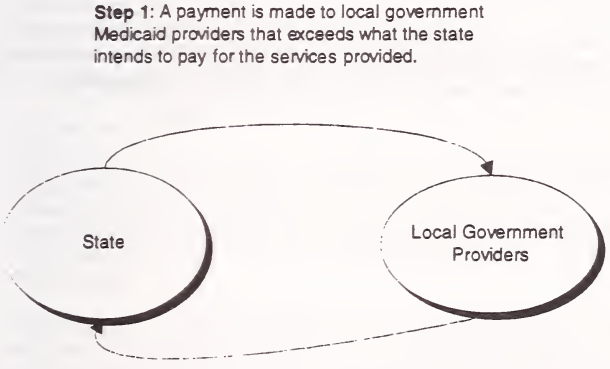
Financing practice	Summary	How subsequently restricted
Excessive payments to state facilities	Excessive payments were made to state-owned facilities, increasing federal payments.	HCFA promulgated regulations in 1987 that established payment limits for state-operated inpatient and institutional facilities.
Provider taxes and contributions	Revenues from provider-specific taxes or donations were used to increase state Medicaid spending. The taxes and contributions were matched with federal funds and paid to the providers. These providers then returned most of the federal monies to the state.	The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 essentially banned provider donations, placed a series of restrictions on provider taxes, and set certain other restrictions for each state.
Excessive disproportionate share hospital (DSH) payments	DSH payments are meant to compensate those hospitals that care for a disproportionate number of low-income patients. Unusually large DSH payments were made to certain hospitals, which then returned the bulk of the state and federal funds to the state.	The Omnibus Budget Reconciliation Act of 1993 limited which hospitals could receive DSH payments, capped the amount of DSH payments individual hospitals could receive, and capped states' total DSH payments. The Balanced Budget Act of 1997 further reduced state-specific DSH allotments for fiscal years 1998-2002.
Excessive DSH payments to state mental hospitals	A large proportion of state DSH payments were directly returned to the state treasury or were paid to state-operated psychiatric hospitals to indirectly cover the cost of services provided to patients that Medicaid cannot directly pay for.	The Balanced Budget Act of 1997 limited the proportion of a state's DSH payment that can be paid to state psychiatric hospitals.

To better ensure that federal Medicaid dollars are used for Medicaid services, in the Balanced Budget Act of 1997 the Congress explicitly banned the use of federal matching funds for any non-health-related items or for any item or service not covered by a state's Medicaid plan.

ADDITIONAL FEDERAL FUNDS ARE OBTAINED THROUGH EXCESSIVE PAYMENTS TO LOCAL GOVERNMENT PROVIDERS

The current practice is a variation of past practices in which federal dollars make a round-trip from the state, to a Medicaid provider, and then back to the state. Under the current scheme, excessive payments are made to health facilities owned by local governments. Such providers include county-owned nursing homes, local hospital districts, and county hospitals. Unlike schemes involving other types of providers, which have been addressed through legislation or changes in regulation, restrictions on excessive payments to local government providers are fewer. The round-trip arrangement that maximizes federal dollars for the state essentially involves two steps, as shown in figure 1.

Figure 1: Overview of Process for Maximizing Federal Medicaid Dollars



In the first step, states make a payment to certain Medicaid providers over and above the amount that Medicaid actually intends to pay them. States determine the amount of the excess payment by computing the difference between the upper payment limit (that is, the maximum amount of total Medicaid expenses eligible for federal matching payments) and the total amount the state would normally pay to Medicaid providers using its payment rates. Local government health care facilities such as nursing homes and hospitals constitute good candidates for these excessive payments because states are not limited in how much they may pay local government providers, as long as their total payments to that provider group as a whole fall below the upper limit for that category of provider. For example, if actual Medicaid payments to all nursing homes in a state were $100 million under normal Medicaid rates, and the upper payment limit was $120 million, the amount available for the excessive payment to county-owned nursing homes would be $20 million.[3] Assuming a 50-percent federal matching rate, the federal share of the aggregate payments would thus be driven from $50 million to $60 million.

The second step is the transfer of all or an agreed-upon share of the excess payments from the local government providers back to the state treasury. Without this step, the local providers would benefit, but the states would realize no financial benefit. In fact, the state would actually lose from the arrangement, because it would simply be paying more than normal for the same services. However, once a payment is made to a local government provider, the funds become local government funds, and the local government is free to make any intergovernmental transfer of the funds. Thus, the states can receive the transfer and reap the financial benefit of the federal share of the excess payment.

While most states are silent on the distribution of excessive payments once the local government providers are paid, some states are quite clear that the money is intended to complete the round-trip and be returned to the state (see table 2 for examples).

[3]When the excess payments are made, they are a combination of federal and state funds.

Table 2: Examples of State Plan Descriptions of Disposition of Excess Payments

State	Excerpts from state plan amendments	Status*	Effective date
Alaska	"While it is probable that some portion of the payments will be retained by the publicly owned and operated hospitals, Alaska intends that the largest share of the payments will be returned to the State through an intergovernmental transfer."	Pending	Deemed approval estimated for November 2000
South Dakota	"A government nursing facility funding pool is created to increase payments to nursing facilities that are owned by political subdivisions of the state (publicly owned). . . Each publicly owned nursing facility, upon receiving a distribution of the funding pool, remits the amount of that payment, less a transaction fee, to the Department of Social Services thereby creating an intergovernmental transfer of funds."	Pending	Deemed approval estimated for September 2000
Tennessee	". . .(B)ased upon an executed intergovernmental transfer agreement and subsequent transfer of funds, qualifying Medicaid level II nursing facilities shall receive a Medicaid nursing facility level II disproportionate share payment one time each fiscal year."	Deemed approved	July 2000
Washington	"The supplemental payments made to public hospital districts are subject to. . .a contractual commitment by each hospital district to return a minimum of 82% by intergovernmental transfer to the state treasurer. . ."	Approved	September 1999

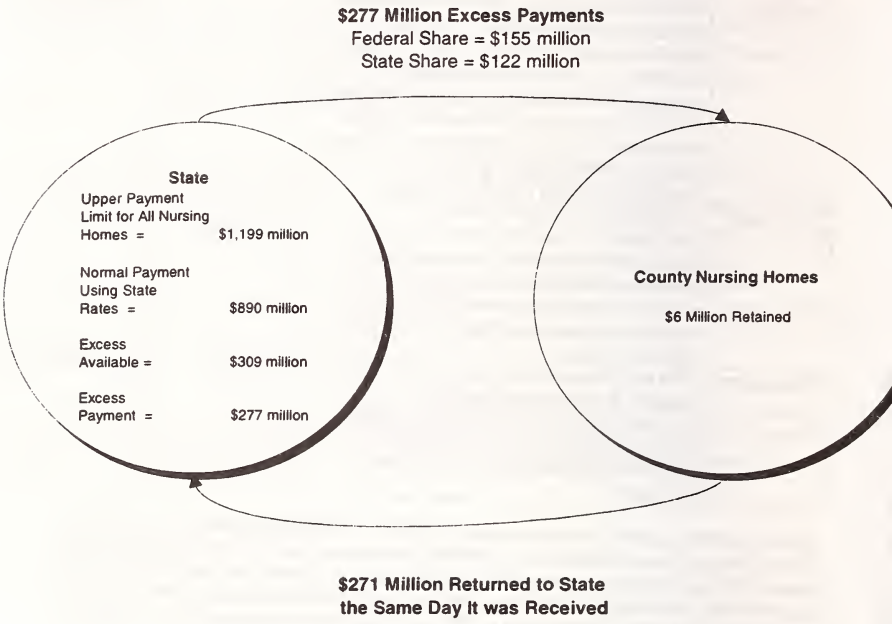
*By law, if HCFA neither denies nor approves plan amendments submitted by the states within 90 days, the amendments automatically become accepted and approved. In some cases, HCFA does not have grounds to deny the state proposals but will not officially approve them. As a result, these proposals become "deemed approved" after 90 days. In some cases, this process extends up to 180 days if additional information is requested from the state.

Figure 2 shows how the round-trip payment process works in one state we examined in prior work, illustrating how long the practice has prevailed. The illustration is based on a financing arrangement between the state of Michigan and some county nursing homes. We first reported on it in 1994.[4] As illustrated, the state determined that it could pay an

[4]See Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government (GAO/HEHS-94-133, Aug. 1, 1994).)

additional $277 million to county nursing homes and still stay under the upper payment limit for all nursing homes. Michigan then made a payment of $277 million, which included $155 million in federal matching funds, to the homes. On the same day that the county facilities received the money, they wired $271 million of the payment back to the state. None of these funds were returned to the federal government but instead were intended to reduce the state's share of Medicaid payments.

Figure 2: Michigan's Excessive Payment Arrangement With County Nursing Homes, 1993



Several variations to this basic approach exist among state plans. For example, in one state, county-owned nursing homes obtain the equivalent of a bank loan to finance both the state and federal shares of the excessive payment. The county-owned nursing homes transfer the total amount borrowed to the state, which returns all the funds plus a transaction fee to the county-owned nursing homes as a Medicaid payment for nursing services. The nursing homes use the payment to pay off their loans. The net result of this variation is the same: hundreds of millions of dollars in federal funds are generated with ultimately no state contribution.

The exact amount of additional federal Medicaid matching dollars generated from states' use of these practices is unknown, but it is likely substantial and increasing. HCFA estimates that of a $3.4 billion increase in its fiscal year 2000 spending above earlier projections, $1.9 billion was likely due to the circulation of funds through round-trip arrangements with local government providers. According to HCFA, as of July 26, 2000, 17 states had approved state plans that would permit the use of this reimbursement practice, and another 11 states have submitted proposed plan amendments for approval to do so. The quick and dramatic increase in Medicaid expenditures that accompanied the adoption of schemes involving DSH payments in the early 1990s shows the potential of the current financing arrangement to increase expenditures. In that earlier set of schemes, DSH payments increased from $1 billion in 1990 to over $17 billion in 1992.

Because HCFA regulations currently allow excessive payments as long as they do not exceed the upper payment limit, HCFA's position is that it has no grounds to deny these plans. A review of just a few of the proposals, approved plan amendments, and various media reports shows the potential for generating a significant amount of additional Medicaid federal matching dollars without assurances that the money will be spent on Medicaid services and beneficiaries.

- Iowa's plan, which took effect last year, pays county nursing homes this year about $95 million and will pay an estimated $125 million in 2001 in additional federal dollars.[5] These payments will result in average federal spending of about $969 daily per Medicaid bed in county nursing homes, or a 1,700-percent increase from the current federal spending level of $54 per bed per day. While Iowa's plan does not specify how these funds will be spent, a state Medicaid official told us the funds will be returned to the state to create a trust fund that will be spent on assisted living for the elderly, which may or may not be related to covered Medicaid services or beneficiaries.

- New Jersey's plan, which lapsed into effect September 1, will generate an additional federal payment of about $500 million over a 15-month period by increasing payments to county nursing facilities by $999 million. The counties initiate the excess payment by transferring the total expected excess payment amount, both state and federal shares, to the state. The state immediately sends the money back to the county facilities as a Medicaid payment. This state payment triggers the federal share of the payment, which it can then spend at its discretion.

- Media reports from some other states have cited elected officials' plans to use the federal funds for state education programs or to subsidize a state tax cut.

[5] This year's excess payment amount is based on a 9-month period. In 2001, the payment amount will be based on a full 12 months, which is the basis for our estimate.

FINANCING SCHEME UNDERMINES CONGRESSIONALLY DETERMINED FEDERAL SHARE OF MEDICAID EXPENDITURES

The fiscal integrity of the Medicaid program is a shared federal/state responsibility. As such, states have considerable programmatic flexibility but also the fiduciary responsibility to manage program finances efficiently and economically and to make responsible spending decisions. Because states share in the program costs, they have a strong incentive to contain health care costs through prudent program decisions.

The current funding arrangements with local government health providers undermine this incentive and circumvent the federal and state funding balance that is set by law. These funding arrangements effectively increase the federal matching rate by increasing federal expenditures, while total state contributions remain unchanged or even decrease. For example, we reported in 1994 that the state of Michigan increased its federal matching rate from 56 percent to 68 percent by reducing state payments by $773 million through several different funding practices. These practices included the funding arrangement explained in figure 2.

The current excessive payment rates used or proposed by states have the same potential. For example, under New Jersey's excessive payment plan to county nursing facilities, an additional $500 million in federal funds will be paid over a 15-month period. While the state has not indicated how much of this payment it will ultimately retain, keeping all additional federal funds would have the effect of increasing the federal share from 50 percent to 62 percent. HCFA is aware of 15 other similar plan amendments involving local government nursing homes. Together, these 16 state funding arrangements, if they all take effect, could result in over $2 billion in annual excessive federal payments.

Restricting the Size of Excessive Payments Can Limit Financing Schemes

In the past, efforts to curtail round-trip financing schemes have focused on restricting the size of the excessive payments. The same approach can be taken for the current scheme. More specifically, in 1987, in response to some states' excessive Medicaid payments to state-operated facilities, HCFA promulgated regulations that established separate upper payment limits for state-owned facilities in certain provider categories. Expanding this approach to include all government-owned Medicaid providers would essentially shrink the upper payment limit loophole and reduce the financial benefit of current financing arrangements with local government providers. For example, if an upper payment limit was established for payments to all government providers, the federal share of the excessive payment amount in Iowa could be reduced from over $95 million to less than $3 million. This decline would occur because the excess amount available for payment would be reduced from $151 million for all nursing homes to about $4 million for nursing homes operated by local governments.

Some action on this front is under way. In response to the increasing magnitude of the current payment schemes, HCFA has drafted regulations that, if put into effect, would curtail excessive payments to local government providers in the same manner as for state-owned facilities. HCFA officials acknowledged that they had been aware that some states have been using the current scheme for a number of years. They said they had become more motivated to take action because of the increasing number of states submitting plans to use the scheme and the drain of federal dollars as a result. HCFA's draft regulations are awaiting approval from the Office of Management and Budget (OMB). If OMB approves them, the regulations must undergo a public comment period before they can take effect. HCFA officials were unable to definitively estimate when proposed regulations would be issued for public comment.

CONCLUSIONS AND PREVIOUS RECOMMENDATION

The financing scheme that states are increasingly using is basically no different from the schemes that have been identified and subsequently prohibited in the past. The current schemes take advantage of a technicality that allows states to, in effect, supplant state Medicaid dollars with federal Medicaid dollars. In so doing, states violate the basic integrity of Medicaid as a joint federal/state program.

HCFA's proposed regulatory change, which would impose an upper payment limit on providers owned by local government entities, would extend the existing limits on payments to state-owned facilities. While such a change would probably not discourage other attempts to find ways to increase federal payments, it would at least curtail the scheme now in widest use. Because of the potential for excessive payments to persist in other forms, the Congress should consider implementing a recommendation that remains outstanding from our 1994 work to enact legislation to prohibit Medicaid payments that exceed costs to any government-owned facility. Finally, continuing attempts to exploit program loopholes also point to the need to be ever vigilant to identify the next innovative arrangement before it reaches such financial magnitude that it becomes both a staple of state financing and a potential threat to the integrity of the funding partnership.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Committee may have.

GAO CONTACT AND STAFF ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call Kathryn G. Allen at (202) 512-7118. Frank Pasquier, Tim Bushfield, Robert Crystal, Evan Stoll, and Stan Stenersen also made key contributions to this testimony .

RELATED GAO PRODUCTS

Medicaid in Schools: Poor Oversight and Improper Payments Compromise Potential Benefit (GAO/T-HEHS/OSI-00-87, Apr. 5, 2000).

Medicaid in Schools: Improper Payments Demand Improvement in HCFA Oversight (GAO/HEHS/OSI-00-69, Apr. 5, 2000).

Medicaid: Disproportionate Share Payments to State Psychiatric Hospitals (GAO/HEHS-98-52, Jan. 23, 1998).

State Medicaid Financing Practices (GAO/HEHS-96-76R, Jan. 23, 1996).

Michigan Financing Arrangements (GAO/HEHS-95-146R, May 5, 1995).

Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government (GAO/HEHS-94-133, Aug. 1, 1994).

(201094)

Testimony of
Michael F. Mangano
Principal Deputy Inspector General

Mr. Chairman and members of the committee, I am Michael F. Mangano, Principal Deputy Inspector General for the Department of Health and Human Services. I am here today to discuss our ongoing work concerning States' use of manipulative financing schemes that exploit a provision in Medicaid's "upper payment limit" regulations that govern enhanced payments to certain providers. Specifically, I will describe how some States are using intergovernmental transfers to artificially generate excessive Federal matching payments at the expense of the other States and contrary to the intent of the program.

These abusive practices increase the Federal share of Medicaid without a corresponding increase in the States' share or in the amount or quality of services provided to Medicaid patients. Under these schemes, the benefitting States' share of the cost of their Medicaid programs declines, and, in effect, Federal taxpayers in other States pay more than their share of Medicaid because some States are using these methods. The Health Care Financing Administration (HCFA) estimates the Federal loss to be approximately $2 billion this year and $12 billion over 5 years. And, these estimates assume no additional States will use these types of financing schemes to increase their Federal matching funds. We are reviewing a number of State programs, and results from the first three reviews corroborate HCFA's concerns. Based on our work to date, we believe that widespread manipulation by States of the upper payment limit requirements described in today's hearing could undermine the stability of the Medicaid program.

In addition to using the excessive matching funds to pay for Medicaid services that were not in the approved State plan amendment, some States also appear to be using Federal Medicaid dollars to pay for non-Medicaid activities, contrary to the purpose of the Law.

Current law allows States to make enhanced payments to certain providers within a category, like hospitals or nursing homes. My testimony today focuses on alleged enhanced payments to county-owned nursing homes. These enhanced payments are capped by an upper payment limit that I will describe in more detail later.

The combination of the enhanced payment provision and intergovernmental transfer capabilities between State and local governments has produced an abusive scenario in which some States (1) violate the intended purpose of the Medicaid program to be a Federal/State jointly funded program, (2) divert the enhanced payments away from their intended purpose of improving the quality of care in nursing homes and hospitals, (3) redirect the Federal Medicaid funds generated from this scheme to other Medicaid services or non-Medicaid programs, and (4) fail to base the enhanced payments on prior or anticipated costs at the nursing home facilities.

In our opinion, the mechanisms I will describe were unfairly designed solely to generate excessive Federal Medicaid reimbursements and effectively evade the statutory Federal/State Medicaid matching requirements. Consistently, our reviews are showing that the vast majority of so-called enhanced payments made through intergovernmental transfer schemes are not provided directly to the participating county-owned nursing facilities they were purported to

assist. Instead, they are returned to their source, and the Federal funds generated from these transfer schemes are ultimately diverted, sometimes into States' revenue accounts that can be used for non-Medicaid purposes. And, when a State uses the returned funds to make Medicaid payments, Federal funds are, in effect, being used to generate additional Federal funds.

The Medicaid Federal/State Partnership

Title XIX of the Social Security Act (Act) authorizes Federal grants to States for Medicaid programs that provide medical assistance to needy beneficiaries. Since the inception of the Medicaid program, the Federal Government through the Health Care Financing Administration (HCFA) and the States have shared in the cost of the program.

States incur expenditures for medical assistance payments to medical providers who furnish care and services to Medicaid beneficiaries as part of a State plan which is approved by HCFA. The Federal Government pays its share of medical assistance expenditures to a State according to a defined formula outlined in sections 1903 and 1905(b) of the Act. The Federal share of medical cost, referred to as Federal financial participation (FFP), ranges from 50 percent to 83 percent, depending upon each State's relative per capita income.

State Medicaid programs have flexibility in determining payment rates for their Medicaid providers and for the use of local government resources to pay the non-Federal portion of these payments. In making payments under an approved State Medicaid plan, a State is required to ensure the payment for services reflect a sense of efficiency, economy, and quality of care. However, present regulations allow States to pay different rates to the same class of providers (for example not all hospitals or nursing homes have to be paid the exact same reimbursement for a service), as long as the payments, in aggregate across the State, do not exceed an upper payment limit which is defined as a reasonable estimate of what Medicare would have paid for the services rendered by this class of providers. This aggregate payment limit applies to all facilities in the State whether they be private, or State and/or local government operated.

Because there is not a separate aggregate limit that applies to only local government operated facilities, these types of facilities are grouped with all other facilities when calculating aggregate upper payment limits. However, State Medicaid agencies, without violating the upper payment limit regulations, direct enhanced Medicaid payments only to local government owned facilities, while not paying enhanced payments to other facilities. These enhanced payments to local government-owned facilities are over and above the basic Medicaid payments made to facilities that provide services to Medicaid eligible individuals. States are not required to justify to HCFA the details of why these enhanced payments are needed nor why they are only made to local government-owned facilities.

How the Financing Technique Works

Some States have developed financing schemes involving, in some cases, overnight intergovernmental fund transfers between State and county governments and accounting transactions that result in little or no State outlays of funds yet reap hundreds of millions of dollars in Federal funds. The general scheme is that States use intergovernmental transfers and

the flexibility inherent in the present upper payment limit rule to finance enhanced Medicaid payments to only county-owned nursing facilities.

As of the date of this hearing, we have substantially completed reviews in three States: Pennsylvania, Alabama and Nebraska. There are other reviews underway. Although the specifics of the enhanced payment programs and associated financing mechanisms differed somewhat in the three States we have reviewed thus far, they share some common characteristics.

- States did not base the enhanced payments on the actual cost of providing services or increasing the quality of care to the Medicaid residents of the targeted nursing facilities.

- The counties involved in the enhanced payment scheme provided little or none of the sham enhanced payments to the participating nursing facilities to provide services to Medicaid residents. Instead, the counties returned these funds to their original source: to the State's general funds and/or the funds were used to repay loans that were made to initiate the transaction.

- The States were clear winners in that they were able to reduce their share of Medicaid costs and cause the Federal government to pay significantly more than it should for the same volume and level of Medicaid services. The Federal share of the enhanced funding went into State accounts and, in some cases, could be used for any purpose.

- Some State's effectively recycled the Federal funds received from these enhanced payments to generate additional Federal matching funds.

Keep in mind this scheme involves only enhanced payments, not the regular Medicaid payment made to a facility which is usually a per diem amount paid to a nursing facility for each Medicaid resident.

We have provided a more in-depth discussion of our work in Pennsylvania, Alabama, and Nebraska in the Appendix to this testimony. I will provide an abbreviated description here to illustrate.

Pennsylvania:
The Pennsylvania State government calculated a maximum allowable enhanced payment amount that could generate a corresponding Federal match. It obtained county government agreements to have twenty counties borrow and transfer, for only one day, tens of millions of dollars into a State bank account. The State immediately repaid the amount to the same county governments, labeling the transaction as a transfer of enhanced payments to the counties for their county-owned Medicaid nursing facilities. The State then billed the Federal government for the Federal share of the enhanced payments. The remitted Federal share was commingled in State accounts that could be used for any purpose the State wished.

Alabama and Nebraska:
In Alabama, and Nebraska, a slight twist in this scheme was used. Each of these two States created a State-maintained funding pool to increase reimbursement to county government-owned nursing facilities. The State calculated the funding pools by determining the difference between the upper payment limit (based on Medicare payment principles) and the regular allowable Medicaid payments made to all of these facilities. The combined total of the differences for all facilities in the State represented the funding pool. The initial source of the State's share of the funding pool was the States' general fund. With the State's share available, Federal matching funds were claimed. The funds in the pool, including Federal and State share, were then transferred to the county providers as a Medicaid enhanced payment. Within a short time frame, the nursing facilities returned the majority of the enhanced payment to the States.

Where we have a problem:
These methods in Pennsylvania, Alabama, and Nebraska sound simple and maybe even legitimate. However, the scheme is that little or none of the funds that the States transferred to the counties, allegedly for the use of the nursing homes, was actually used by the nursing homes. In Pennsylvania, the county government used the money that was transferred back from the State to pay off their one-day loans. None of the funds went to the nursing homes. In Alabama and Nebraska, once each county nursing facility received the enhanced payment, it immediately transferred the majority of the funds back to the States. Little or none of the funds was retained by the nursing facilities for the benefit of their Medicaid residents.

The gain from these schemes accrued to the State government, not the Medicaid facilities or beneficiaries. In Pennsylvania, the State commingled the Federal match that was generated by these sham enhanced payments in their general fund, in effect making them available for any purpose, including to become part of the State amount needed to obtain additional new Federal funds. In Alabama, the Federal share, and the State's bogus enhanced payment that was returned by the counties, were used for Medicaid expenses other than the intended enhanced payments, in effect substantially reducing the State's share of its regular Medicaid cost. In Nebraska, the State and Federal funds were placed into general and health designated accounts for various uses, some of which could be non-Medicaid.

These financing schemes seem remarkably similar to the tax and donations schemes the States used to generate Federal funds several years ago. The Congress moved to put a halt to this practice in the early 1990's. The gimmick was to encourage health care industry associations to "donate" funds to States who, in turn, raised Medicaid payments to these associations' provider members to unusually high levels. These high payments created unjustified Federal participation funding, enough to pay back the hospitals for their donation and increase the States' general funds with Federal dollars. The actual net increase in Medicaid funds paid to the providers for actual medical services was minimal, if there was any increase at all.

The tax scheme was similar with facilities agreeing to be taxed by the State which used these taxes as their share to obtain Federal matching funds and then increased Medicaid payments to the facilities to make up for their taxes.

Actions Needed

The HCFA has drafted a regulation to redefine which types of facilities are included in upper payment limit classifications. We fully support a regulatory change that eliminates this financial gaming of the Medicaid program. Should the Congress want to act to close this loophole, we recommend you specifically:

- Require that, for States to seek Federal financial participation to match State enhanced payments, they must demonstrate that the enhanced payments were actually made available to the facilities and the facilities used the funds for Medicaid beneficiaries' care.

- Authorize a civil penalty against the States specifically for using Medicaid funds for purposes other than State plan approved purposes.

- Require that any special payments, such as these enhanced or supplementation payments being used by States in this funding scheme, must be based on prior costs rather than a simple maximization based on the upper payment limits.

- Declare that the return of Medicaid payments by a county or local government to the State should be declared a refund of those payments and thus be used to offset the Federal financial participation generated by the original payment.

Conclusion

At this point, we are just beginning to assess the full effect of these programs on the Federal treasury. In addition to the three reviews I described, we are also performing audit work in Illinois, Washington and North Carolina. We should have results from these States shortly.

The HCFA has identified 19 States with approved plans currently using intergovernmental transfer programs and has received requests by an additional 9 States to implement new enhanced payment program plans. To repeat my earlier statement, based on our work to date, we believe that widespread manipulation by States of the upper payment limit requirements described in today's hearing could undermine the stability of the Medicaid program. Our concern is heightened by the fact that HCFA estimates that, even though the number of Medicaid beneficiaries is decreasing, Federal Medicaid spending for Fiscal 2000 has increased by $3.4 billion over earlier projections, with a large portion of this due to the funding schemes involving enhanced payments.

We believe that these programs are a replay of the tax and donation funding schemes that Congress moved to halt in the early 1990s. The combination of enhanced payments and related intergovernmental transfer programs must be brought under control to safeguard the Federal/State financial partnership in the Medicaid program and to maintain its financial stability. This concludes my testimony. I welcome your questions.

Appendix

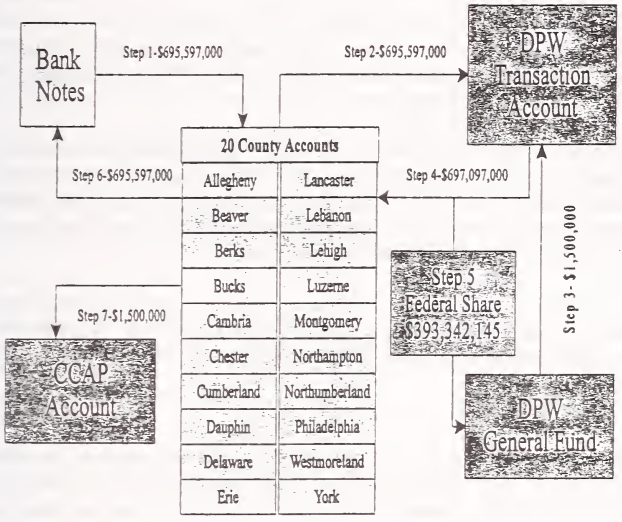
Results of OIG Work to Date

Pennsylvania:
In Pennsylvania, the Department of Public Welfare (DPW) administers the Medicaid program. Under its HCFA approved State plan, DPW makes enhanced payments to 23 county nursing facilities owned by 20 counties. These enhanced payments, which are over and above the regular Medicaid payments to these facilities, are called supplementation payments.

As part of the supplementation payment process, each year DPW determined the available funding pool by calculating the amount of Medicaid funds available under the Medicare upper limit regulations. It then entered into an agreement with the County Commissioners Association of Pennsylvania (CCAP) whereby the counties borrowed funds from a single bank using tax and revenue anticipation notes which may be equal to the total amount of the funding pool. The county funds maintained at that bank were then transferred to a DPW bank account, also at that same bank, as the initial source to fund the pool. Within 24 hours of receipt, DPW transferred the amount received from the counties, plus a $1.5 million program implementation fee, back to the county bank accounts as Medicaid supplementation payments for nursing facility services. The counties then forwarded the unused portion of the program implementation fee to CCAP. The counties used the supplementation payments to pay the bank notes. The DPW reported the supplementation payments to HCFA as county nursing facility supplementation payments and claimed Federal financial participation.

As demonstrated, the reported supplementation payments allegedly intended for the county-owned nursing facilities were not really payments at all. They were merely transfers of funds between county bank accounts and the account maintained by DPW. The transactions were generally completed within 24 hours, and except for a $1.5 million program implementation fee, the funds never left the bank that maintained the accounts for DPW and the counties. The chart on the following page illustrates the flow of funds for the most recent intergovernmental transfer transaction of June 14, 2000.

INTERGOVERNMENTAL TRANSFER
JUNE 14, 2000



As shown in the illustration, the counties borrowed $695,597,000 (Step 1) and transferred it to the DPW transaction account (Step 2). The DPW added a $1,500,000 transaction implementation fee to the DPW transaction account (Step 3), transferred $697,097,000 as Medicaid supplementation payments to the county bank accounts (Step 4), and claimed $393,342,145 in FFP (Step 5). The counties used the supplementation payments to satisfy the bank loans (Step 6) and transferred the unused portion of the transaction implementation fee to CCAP (Step 7).

None of the supplementation payments reached the participating nursing facilities, and the Medicaid residents received no additional services. Pennsylvania retained the entire $393,342,145 in Federal financial participation to use as it pleased. This was the second of two intergovernmental transfer transactions processed in State Fiscal Year (SFY) 1999. The first transfer provided for supplementation payments of $823,907,000, generating $464,793,744 in Federal financial participation.

Our review also found that during the period SFY 1992 to SFY 1999, DPW reported $5.5 billion in supplementation payments, none of which was ever paid directly to participating county owned nursing facilities. These reported supplementation payments generated $3.1 billion in Federal matching funds without any corresponding increase in services to the Medicaid residents of the participating county nursing facilities. Further, in the last 3 years (SFYs 1997-1999) about

21 percent of the Federal match generated by the intergovernmental transfer transactions was not even budgeted for Medicaid purposes, and another 29 percent remained unbudgeted and available to Pennsylvania for non-Medicaid related use.

What is especially alarming is the rapid growth in DPW's supplemental payments and the corresponding increases in the Federal share. For example, the Federal match generated from this financing technique doubled from $221 million in SFY 1995 to $438 million in SFY 1997 and nearly doubled again to $858 million in SFY 1999.

The net effect of DPW's intergovernmental transfer financing mechanism was that the Federal Government paid significantly more for the same level of Medicaid services, while the DPW paid significantly less. We determined that for Federal Fiscal Year 2000, the effective FFP matching rate was about 65 percent of total Medicaid expenditures, or 11 percent higher than the 54 percent average FFP rate under the statutory formula.

Since DPW was still below the Medicaid upper payment limit, we fully expect that its supplementation payment program will continue to generate about $900 million in excessive Federal financial participation per year if HCFA does not take action to stop this abusive and costly practice.

Alabama:
Alabama's program began in September 1999 and began making enhanced payments to nine county-owned hospital based nursing facilities. Each year Alabama determined the available funding pool for enhanced payments by calculating the amount of funds available under the upper limit regulation. Next, the State transferred the enhanced payments, including the State and Federal Share, to the eligible nursing facilities on a monthly basis. Within a few days of receiving the enhanced payments, the nursing facilities returned 96.5 percent to Alabama. The nursing facilities used the retained portion (3.5 percent) of the enhanced payments to pay for facility expenses. Alabama deposited the returned portion (96.5 percent) into a fund used to pay Medicaid expenses.

During FY 1999 and 2000, Alabama reported $83.5 million in enhanced payments generating $58.5 million in Federal matching funds. Subsequent to the initial payment by the State, approximately $80.5 million was returned to the State and only about $3 million was retained by the nursing facilities. The returned funds were commingled with other funds used to pay for Medicaid expenses. The net gain of this financing scheme to Alabama was $55.5 million ($58.5 million Federal share less $3 million retained by the nursing facilities).

Nebraska:
In 1992, Nebraska began an enhanced payment program to city and county owned nursing facilities. In 1998, HCFA approved a State plan amendment which greatly expanded the States' enhanced payment program. Each year, Nebraska determined the available funding pool for enhanced payments by multiplying the difference between the Medicare payment rate and the Medicaid rate applicable to each facility by the facility's total Medicaid resident days. The combined total of the differences for all facilities in the State represented the funding pool for enhanced payments. The State then transferred the enhanced payments, including the State and

Federal share, to the eligible nursing facilities. Immediately upon receipt, the nursing facilities transferred the enhanced payments less a $10,000 per facility participation fee back to the State. Of the funds returned, Nebraska deposited an amount equal to the State share of the enhanced payments to the State's general fund. The remaining funds were deposited in the Nebraska Health Care Trust Fund and from there disbursed into three additional Health Care Trust Funds.

During FYs 1998 through 2000, Nebraska reported $227 million in enhanced payments generating $139 million in Federal matching funds. Subsequent to the initial payment by the State, approximately $225.5 million was returned to the State and only about $1.5 million in participation fees was retained by the nursing facilities. Of the returned funds, $88 million was deposited in the State's general fund and $137.5 million was transferred to the Nebraska Health Care Trust Fund. As of April 30, 2000, the four Health Care Trust Funds had available balances totaling almost $137 million. The net gain of this financing scheme to Nebraska for the past three years was $137.5 million ($139 million Federal share less $1.5 million in participation fees retained by the nursing facilities).

TESTIMONY OF
TIMOTHY WESTMORELAND, DIRECTOR
CENTER FOR MEDICAID AND STATE OPERATIONS
HEALTH CARE FINANCING ADMINISTRATION
on
MEDICAID UPPER PAYMENT LIMITS
before the
SENATE FINANCE COMMITTEE
September 6, 2000

Chairman Roth, Senator Moynihan, distinguished Committee members, thank you for inviting us to discuss concerns we share regarding States' use of Medicaid upper payment limits. As you know, some States are using the flexibility in setting the maximum rates that can be paid to Medicaid providers -- the so-called upper payment limits -- to obtain Federal matching funds in ways that are inconsistent with the intent of the Medicaid statute. Some States are using these matching funds for worthy purposes, such as supporting public hospitals and other health care programs. While these other programs are laudable, some are not eligible for federal Medicaid funding. In other States, it is unclear what the money is used for, and in some cases it appears to be going for programs that are unrelated to health care.

The HHS Inspector General's findings on this are troubling. In all States engaged in these practices, the Federal funds are being obtained without the statutory State matching contribution, and without the accountability that is essential in all public programs. The five-year cost of this growing State practice is likely to be in the tens of billions of dollars, and there is an influx of new State proposals.

Existing regulations never anticipated these abuses. To end these abuses, we must issue a proposed regulation that will modify the current upper payment limits for non-State public facilities, thereby limiting the accounting maneuvers that have allowed States to questionably obtain federal matching funds. To help States adjust and prevent potential adverse impact on health care programs, there will be adequate transition provisions to phase in the new policy. We will also take into account the need to assure that public hospitals can continue to meet their mission of serving Medicaid and uninsured patients.

The practical outcome is that the States using this financing mechanism actually gain Federal matching payments without any new State financial contribution. In fact, through these practices, it is possible for a State that should receive $1 in federal funds for every State dollar spent on Medicaid to instead receive $5 or more in federal funds for every State dollar spent. In addition, if a State requires county or municipal facilities to refund its own Medicaid contribution, the practice also effectively undermines the requirement that a State share in the funding for its Medicaid program.

Moreover, this practice appears to be creating rapid increases in Federal Medicaid spending, with no commensurate increase in Medicaid coverage, quality, or amount of services provided. There is preliminary evidence that this current practice has contributed to a spike in Federal Medicaid spending. The States' estimates of Federal Medicaid spending for FY 2000 have already increased by $3.4 billion over earlier projections. Assuming additional States come forward with State plan amendments, the five-year cost of this growing State practice can be in the tens of billions of dollars. Currently, 19 States have approved plan amendments and 14 have pending amendments (for a total of 28 States because some have both pending and approved amendments). This could have the long-term effect of undermining the core mission and the broad-based support for Medicaid, which guarantees critical health services to our most vulnerable populations: low-income children and families, people with disabilities, and the elderly.

The excess Federal Medicaid payments that are shared with State and local governments are put to any number of uses--both health- and non-health-related. It appears some States allow public hospitals to keep a portion of these funds to help pay for uncompensated care. While the Medicaid disproportionate share hospital (DSH) program was created to cover these costs and now accounts for more than $14 billion annually in total Medicaid spending, the DSH program has not always met the growing challenge of caring for the uninsured. Some States have, through the UPL arrangement, circumvented the statutory DSH limits--using indirect means to accomplish what the DSH statute does not allow.

Other States are using these payments to pay the statutory State share of Medicaid or of the State Children's Health Insurance Program (SCHIP). While Medicaid and SCHIP are Federal/State partnerships in which each partner pays a share established in statute, the UPL arrangements shift a portion of a State's share to the Federal government. The result is that Federal taxpayers in all States are forced to shoulder more than their share for Medicaid and SCHIP in a few States.

Still other States are using the UPL arrangement to finance other health programs beyond Medicaid and SCHIP. This results in Medicaid funding being used for otherwise laudable health care purposes, but for people and/or services not eligible for Medicaid coverage.

Other reports suggest that some States have gone so far as to use -- or intend to use -- the UPL arrangement for non-health purposes.

- Several States appear to have used it to fill budget gaps.
- Another State's local newspaper reported that Federal Medicaid funds would be used for State tax cuts or for reducing State debt.
- One State announced that it intended to use funds generated through the UPL system to pay for education programs.

These practices, which are effectively general revenue sharing, are inconsistent with the Medicaid statute, Congressional intent, and Administration policy. However, we lack authority under existing regulations to deny State proposals to engage in these arrangements. Furthermore, significant public policy should be made through an open public process. The HHS Office of Inspector General and General Accounting Office have both looked into this and are reporting on some of their findings here today.

We sent a letter to States in July describing all these concerns and giving notice of our intention to act to stop this inappropriate use of Federal funding. States and hospitals have, understandably, expressed concern about the impact on other health care programs. We share these concerns, and are committed to both ending inappropriate use of federal funds and establishing appropriate transition provisions to help States adjust to necessary policy changes.

Proposed Regulation

We will shortly issue a proposed regulation to address these concerns. The proposed rule will create some type of separate reimbursement limits for non-State public facilities. States will no longer be able to pool amounts for both private and non-State owned public facilities and claim the total of that pool for federal matching funds. Recognizing higher costs incurred in public hospitals, we will include provisions to ensure adequate reimbursement rates for these facilities.

To help States adjust, we will make a gradual transition to the new policy. Specifically, we anticipate a multi-year transition that would not affect any State with an approved UPL policy in 2001. We will solicit comments on our proposed changes to the UPL policy, as well as the transition provisions, and we are open to other courses of action that will accomplish the same goals set out in the proposed rule.

We understand that change will be difficult--just as it was in the early 1990's when the Federal/State financing relationship had to be re-adjusted because of now illegal State funding mechanisms of donations and taxes. We will specifically solicit comments on proposed transitional periods to address this reliance.

Other Efforts

The Administration is committed to supporting health care providers who serve the uninsured and chronically ill and to assuring that they can continue to do so. The President's budget includes more than $100 billion over 10 years to expand health insurance to the uninsured. These funds would reduce the uncompensated care in public hospitals. It also includes a long-term care initiative and Medicare and Medicaid provider payment restoration initiative that explicitly targets funding to nursing homes and hospitals, which will also help institutions directly. We have urged the Congress to pass this initiative this year.

CONCLUSION

The Medicaid program has been successful over the years in providing vital health care services to millions of low-income Americans. It will continue to be successful only to the extent that it adheres to that mission and ensures that the funds provided are used appropriately and that the program retains its integrity. The program will enjoy public support only if it maintains public trust.

We appreciate the need to proceed with caution in addresing UPL abuses in order to ensure that there is no adverse impact on worthy but now improperly funded health care programs. But we also understand the need to act decisively to ensure that Federal funds are spent in accordance with the law. I thank you for holding this hearing, and I am happy to answer your questions.

# # #

SENATE FINANCE COMMITTEE HEARING
on
"MEDICAID UPPER PAYMENT LIMITS"
September 6, 2000

SEN. MOYNIHAN -- The question I would like to ask is, "what is Medicaid-eligible today"? In 1965, when we passed the legislation it was very simple: if you received Aid to Families with Dependent Children, you were eligible for Medicaid. It was clear. Well, in 1996, we abolished Aid to Families with Dependent Children. So, what are the current criteria for Medicaid eligibility? Could you give us a paper on that?

MR. WESTMORELAND -- As requested, attached to the transcript is a copy of an April 7, 2000, letter HCFA sent to State Medicaid Directors addressing reinstatement of people improperly terminated from Medicaid as a result of Temporary Assistance to Needy Families (TANF). Also attached is a HCFA publication entitled "Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World" that gives more detailed information. Briefly, the current criteria is as follows:

Medicaid eligibility for low-income families and children is no longer linked to receipt of cash assistance. However, Medicaid eligibility is still linked to many of the rules and methods of the old Aid to Families with Dependent Children (AFDC) program. States have a great deal of flexibility, but are still required to follow many of the old AFDC policies.

When Medicaid for low-income families was delinked from receipt of cash assistance in 1996, a new Medicaid eligibility group for low-income families was established under section 1931. Under section 1931, States are required to provide Medicaid to families with dependent children whose countable income and resources are below the eligibility standards in the State's old AFDC State plan, whether or not these families receive cash assistance. However, countable income and resources must be determined using the old AFDC policies which were in effect on July 16, 1996. Dependency must also be determined using those policies and the child must be living with a specified relative as determined under AFDC policies.

However, section 1931 does give the States flexibility to adopt less restrictive methods of determining countable income and resources than the methods that were used under AFDC. Usually, this allows States to coordinate income and resource eligibility for TANF and Medicaid by adopting, for this group, any less restrictive methodologies that they have chosen to use to determine eligibility for TANF. Section 1931 also gives States the flexibility to continue waivers of part A of title IV that were in effect on July 16, 1996. Through continuation of an IV-A waiver or changing the definition of unemployment, a State can effectively eliminate the old

AFDC requirement that a "dependent" child be deprived of parental support and care by the absence, death, incapacity, or unemployment of a parent. Most States have taken advantage of this flexibility so that they can provide benefits to all families on an equal basis, including low-income two-parent families. Under section 1931, a State cannot cover TANF cash assistance recipients without also covering similarly situated families who are not TANF cash assistance recipients.

Prior to 1996, if a family lost eligibility for AFDC because of earnings after having received AFDC for three months, the family was entitled to extended Medicaid eligibility for the next six months and an additional six months if certain conditions were met. Since delinkage, a family who has lost eligibility under section 1931 for low income families, is entitled to 6-12 months of extended Medicaid eligibility, so long as they received Medicaid under section 1931 for three months. Loss of cash assistance itself no longer triggers extended Medicaid eligibility.

In addition, there are other Medicaid eligibility groups for children, pregnant women, and caretaker relatives, that are also tied to the old AFDC policies. However, for the most part, these groups are only tied to the AFDC income and resource policies and the statute provides the flexibility to adopt income and resource policies that are less restrictive than AFDC.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administratio

Washington D.C. 20201 – 0001

April 7, 2000

Dear State Medicaid Director:

Over the past few years, States have made enormous progress increasing access to health care coverage for low-income, working families. As a result of eligibility expansions, simplified enrollment procedures, and creative outreach campaigns, millions more low-income children and parents are eligible for health care coverage through Medicaid or through separate State Children's Health Insurance Programs (SCHIP). And yet, at the same time that States have made expansions of coverage a priority, instances in which eligible children and parents have lost out on coverage have come to light.

The delinkage of Medicaid from cash assistance has made it possible for States to offer low-income families health care coverage regardless of whether the family is receiving welfare, but it has created challenges as well as opportunities for States. Last August, President Clinton spoke to the National Governors' Association (NGA) about the importance of ensuring that everyone who is eligible for Medicaid is enrolled, and directed the Department of Health and Human Services (HHS) to take several actions to improve the health care available to low-income families.

Today, I am writing to provide guidance and information that will build on our joint efforts to improve eligible, low-income families' ability to enroll and stay enrolled in Medicaid. We are concerned that some families who left the Temporary Assistance for Needy Families (TANF) program and who remain eligible for Medicaid or Transitional Medical Assistance (TMA) benefits may have lost coverage. In addition, it appears that some children who became ineligible for Supplemental Security Income (SSI) benefits due to a change in the SSI disability rules may not have been continued on Medicaid despite Congressionally mandated requirements.

This letter covers three related topics. First, it outlines a series of actions that all States must take to identify individuals and families who have been terminated improperly and to reinstate them to Medicaid. Second, it clarifies guidance on Federal requirements relating to the process for redetermining Medicaid eligibility. Third, it reviews the obligations imposed by Federal law with regard to the operation of computerized eligibility systems. We have also enclosed a set of questions and answers to help States implement the guidance. We will continue to issue written answers to questions that arise and make those questions and answers available to States on an ongoing basis. Reinstatement for Improper Medicaid Terminations

Supporting Families in Transition

A Guide to Expanding Health Coverage in the Post-Welfare Reform World

Health Care Financing Administration
Administration for Children and Families
Department of Health and Human Services

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This guide serves three major purposes:

- ✔ First, it assists state policymakers and others in understanding what the Medicaid statute and regulations require of states in terms of Medicaid eligibility, enrollment, redetermination, notice and appeal rights, and other program and policy areas. These requirements apply generally in Medicaid, and also specifically to Medicaid applications and eligibility determinations in the welfare context — that is, when families seek or leave TANF assistance. The guide includes information on the ways in which states can work within the statute to strengthen their outreach efforts, simplify their application processes, and broaden Medicaid coverage to reach low-income families with children, independent of TANF.
- ✔ Second, it discusses the Medicaid requirements and options that apply in three common scenarios: 1) when families seek TANF assistance; 2) when families leave TANF assistance; and 3) when families have no contact with the TANF program.
- ✔ Third, it points the reader to the various sources of funding that are available to states to pay for outreach, training, and other activities to help states bring their systems into compliance with the law and increase health insurance coverage for low-income families with children.

The guide is organized into four chapters:

Reaching Families Who Seek TANF Assistance. This chapter addresses the specific circumstances of families seeking TANF assistance. It outlines the Medicaid and CHIP requirements that states must meet when receiving and processing applications from these families, and identifies practices and techniques that states may wish to consider in designing their TANF programs and their application and enrollment processes to ensure maximum participation of families.

Maintaining Coverage for Families Who Leave TANF Assistance. This chapter focuses on the circumstances of families leaving the TANF system. It outlines applicable Medicaid legal requirements and options, and strategies and techniques that states may wish to consider in designing their Medicaid programs and the administration of their TANF programs to ensure maximum continued eligibility for Medicaid and CHIP.

Reaching Families Outside the TANF System. This chapter focuses on the ways in which states can help low-income families who are not seeking TANF assistance to obtain health insurance through Medicaid and/or CHIP. States have an opportunity here to capitalize on the delinkage of Medicaid from welfare eligibility by marketing

Medicaid as well as CHIP coverage as a freestanding support for working families — untied to TANF. This chapter also emphasizes the need to reach out to low-income families and inform them of the health coverage available to them under Medicaid and CHIP.

Funding Opportunities. The final chapter identifies sources of funds that are available to states to pay for outreach, training, and other activities critical to supporting compliance with Medicaid requirements and maximizing coverage of low-income families with children.

Reaching Families Who Seek TANF Assistance

Families seeking assistance under the Temporary Assistance for Needy Families (TANF) program typically first complete an application. All states currently report that they use joint applications for TANF and Medicaid. Therefore, the nature of coordination between the TANF and Medicaid agencies and their procedures has a critical impact on whether or not eligible low-income families obtain Medicaid coverage.

Not every person seeking TANF assistance actually completes the application process. In some states, for example, completion of an application is delayed until a parent conducts a job search. In other cases, an individual may decide not to apply for TANF after all because she secures employment, or for other reasons. Many parents do not realize that, regardless of their eligibility for or receipt of TANF assistance, they, or at least their children, may be eligible for Medicaid or CHIP. In such cases, TANF offices can be instrumental in ensuring that eligible families get enrolled in Medicaid or CHIP.

This chapter outlines the statutory and regulatory requirements under TANF and Medicaid that states must follow in establishing the eligibility rules for low-income families, as well as requirements concerning the Medicaid application and enrollment processes. To help state officials and others considering implementation issues, this chapter also identifies administrative steps and programmatic strategies designed to promote the maximum enrollment of families.

State Requirements and Options under Federal Medicaid Law

A. Mandatory Eligibility Policies

- ✔ **Section 1931 group.** Medicaid eligibility is no longer tied to or based on eligibility for welfare. Nor can states limit Medicaid eligibility only to families receiving TANF benefits. Section 1931 of the Social Security Act establishes rules for Medicaid eligibility for low-income families based on the income and resources of the family. Under Section 1931, states must provide Medicaid coverage to families who:

- have a dependent child living with them;
- have income and resources that would have qualified them for AFDC under the State plan in effect on July 16, 1996; and
- meet certain deprivation requirements (e.g., absent parent) that were in the state's AFDC plan as of July 16, 1996.

Most states have amended their Medicaid state plans to add the new Section 1931 eligibility group for low-income families to replace the former AFDC recipient eligibility group.

✔ **Comparable standards.** Section 1902 (a) (17) of the Social Security Act requires states to establish eligibility standards for a given Medicaid group that are the same for all members of that group. This means that, generally, the eligibility rules must be the same for all Medicaid applicants and recipients within the Section 1931 group.

✔ **Statewide application.** Medicaid statute requires states to apply their policies through all subdivisions of the state. Accordingly, a state's Section 1931 eligibility rules must be the same throughout the state.

B. Optional Eligibility Policies

Under Section 1931, states have the option to modify their July 16, 1996 AFDC state plan requirements by using the flexibilities outlined below[1]. To exercise any of these flexibilities under Section 1931, a state must submit a Medicaid state plan amendment.

✔ **Use less restrictive financial methodologies.** States can use less restrictive income and/or resource methodologies to determine Medicaid eligibility than those in effect under the July 16, 1996 AFDC state plan. By doing so, states can expand coverage to more low-income families with children without obtaining a Federal waiver. For example, a number of states have chosen to disregard a car of any value, as well as interest income, under their TANF programs. Some of these states have adopted the same disregards for their Section 1931 group under Medicaid as they have in their TANF programs. (These types of disregards must be applied equally to all applicants and recipients under the Section 1931 group.)

In addition, some states have chosen to apply more generous *earned income* disregards under TANF and have adopted the same disregards for the Medicaid Section 1931 group. States can apply these disregards to applicants and recipients or, without violating comparability requirements, they can apply such disregards to Medicaid recipients but not applicants, by replacing the "$30 and 1/3" disregards, which applied only to recipients under the AFDC program.

[1]Note that, consistent with the requirement for comparable standards described above, the policies states adopt under the Section 1931 group must apply equally to families receiving and applying for Medicaid. Earned income disregards (see under Use less restrictive financial methodologies) constitute the sole exception to the comparable standards rule; that is, states can apply earned income disregards differently for Medicaid applicants and recipients under Section 1931, because the AFDC rules that underlie Section 1931 eligibility allowed AFDC applicants and recipients to be treated differently in this respect.

- ✔ **Ease deprivation requirements (repeal of the "100-hour" rule).** Under regulations published August 7, 1998, states have increased flexibility to define the deprivation requirements for Medicaid eligibility. Prior regulations prohibited states from providing Medicaid eligibility to two-parent families if the principal wage-earner worked more than 100 hours per month. The new regulation removes the 100-hour definition of deprivation and instead allows states to set a reasonable standard based on hours of work and/or dollar amounts that may take into account family size and/or time elements. This new flexibility allows states to treat one-parent and two-parent families the same under Medicaid even if a distinction existed under the states' 1996 AFDC and Medicaid state plans.

- ✔ **Use less restrictive financial standards.** States can raise their income and resource standards by as much as the rise in the Consumer Price Index (CPI) since July 16, 1996. (Section 1931 also allows states to use income standards that are lower than the July 16, 1996 AFDC standard, but no lower than those in place on May 1, 1988.) Exercising this flexibility, a state may, for example, pass legislation indexing the income and asset standards for its Section 1931 families[2] — without obtaining a Federal waiver and without regard to its policies under TANF.

- ✔ **Continue certain AFDC waivers.** Finally, states are allowed to continue AFDC waivers that were in effect as of July 16, 1996 that relate to income and resource methodologies, deprivation, and the requirement that a child live with a specified relative. Section 1931 provides that these waivers may be continued permanently for Medicaid purposes even after the date the AFDC waiver expires. However, any AFDC provisions that were more restrictive than those in place for Medicaid cannot be continued for Medicaid purposes beyond their expiration.

C. Mandatory Application and Enrollment Policies

- ✔ **Opportunity to apply.** Medicaid regulations (42 CFR 435.906) require states to provide the opportunity for families to apply for Medicaid *without delay*. When states use joint TANF-Medicaid applications or use the state TANF agency to make Medicaid eligibility determinations, the TANF office is considered a Medicaid office. Therefore, TANF offices in these states must furnish the joint application (or a separate Medicaid application) immediately upon request and may not impose a waiting period before providing the application for Medicaid or processing it. These Medicaid requirements also apply to CHIP programs that are Medicaid expansions, and states are encouraged to apply them in the same manner for non-Medicaid CHIP programs as well.

[2] Because of the CPI constraint, a state that has chosen to apply income standards under TANF that are significantly higher than those under its AFDC state plan in effect on July 16, 1996 may not be able to raise the *standards* for its Section 1931 group to the same level. However, such a state could effectively raise the income standard for its Section 1931 group by using the authority to liberalize its financial *methodologies* as explained above. For example, if a state raised the income standard under TANF from $250 per month to $500 per month and wanted to do the same under its Section 1931 group, the state could get the desired result by disregarding an additional $250 of income (or disregarding "the difference between the AFDC standard and the TANF standard by family size") for purposes of Medicaid eligibility.

In states where the TANF application or eligibility is delayed (i.e., because families receive diversionary assistance, are required to conduct an up-front job search, or face any other initial administrative steps), the state must make a separate Medicaid application available immediately, or make the joint application available immediately for purposes of determining Medicaid eligibility. The evaluation of the Medicaid application and the Medicaid eligibility determination must be made by state personnel who are authorized to perform these functions.

✔ **Time frame for eligibility determination**. Federal regulations (42 CFR 435.911) require that Medicaid eligibility for most families and children must be determined within 45 days from the date of application. The date that a TANF-Medicaid application is filed begins the 45-day "clock" for Medicaid eligibility determination. While a few limited exceptions to the 45-day time frame are allowed, such as an administrative or other emergency beyond the state's control, a TANF requirement may not delay a Medicaid eligibility determination. For example, when a family applies for Medicaid and TANF through a joint application but does not qualify for TANF assistance because of a TANF requirement that does not relate to Medicaid (e.g., the living arrangements for teens), the state must make a timely determination of Medicaid eligibility based on the joint application.

States may grant Medicaid eligibility retroactive to the date of application, or to the first day of the month of application. Eligibility must be granted three months retroactive to the month of application if the applicant received services during that period and would have been eligible at the time the services were furnished.

✔ **Exhaust all avenues to eligibility before denial or termination**. Because Medicaid eligibility is not based on TANF eligibility, states may not deny Medicaid eligibility to a family or any family member simply because the family is ineligible for TANF due to employment, time limits, sanctions, or any other reason. Nor can a state deny Medicaid eligibility because a family member loses eligibility under a particular Medicaid eligibility category. Further, it is not acceptable for a state to deny joint applications and then advise families to reapply if they think they may be eligible under another Medicaid category. *States are prohibited from denying or terminating Medicaid eligibility unless all possible avenues to Medicaid eligibility have been affirmatively explored and exhausted.*

Since Medicaid eligibility for families no longer hinges on eligibility for welfare, and since Medicaid generally covers a broader group of children and families than may be eligible for TANF, some or all members of a family that fails to meet TANF eligibility criteria are likely to be eligible for Medicaid. There are many possible avenues to Medicaid eligibility for

family members denied or terminated from TANF assistance, including the Section 1931 group (depending on family income and other state eligibility rules for the group), poverty-level groups, and transitional Medicaid.

✔ **Medicaid denial notice and appeal rights.** Federal regulations (42 CFR, Part 431, Subpart E and 42 CFR 435.912) require that applicants who are denied Medicaid eligibility or individuals who are terminated from Medicaid receive timely notices informing them of the denial, the reasons for the denial, and their appeal rights. With very few exceptions Medicaid coverage for current recipients continues during an appeal. These rights apply to all Medicaid denials and terminations, including those that flow from joint TANF-Medicaid applications.

When a family applies for Medicaid and TANF through a joint application and the family does not qualify for TANF, the denial notice should inform the family that the TANF denial does not mean the family is ineligible for Medicaid.

D. Optional Application and Enrollment Policies

✔ **Facilitate Enrollment in Medicaid and CHIP.** Making both joint TANF-Medicaid applications and Medicaid-only applications available in TANF offices is an important step toward assuring that families get connected with Medicaid or CHIP, no matter what decision they ultimately make about seeking TANF assistance.

- ***Use joint applications.*** TANF offices are a critical site for reaching low-income families since, in most states, virtually all TANF recipients are likely to be eligible for Medicaid. In states that use a joint TANF-Medicaid application, the opportunity to apply for Medicaid must be provided without delay, whether the family applies for TANF or receives diversionary payments or any other assistance. The family cannot be told to come back another time or be sent elsewhere to obtain the application.

  South Dakota uses a joint application for TANF and Medicaid. However, while both programs are supervised by the same operating division and the same case management staff administer the programs, the state's use of separate computer systems for TANF and Medicaid eligibility ensures that when a TANF case is denied, an independent Medicaid eligibility determination is made.

- ***Use separate applications.*** If a state does not use a joint application, it should ensure that Medicaid applications are available at all TANF sites. States with non-Medicaid CHIP programs should also ensure that CHIP applications are available at TANF sites.

- *Use both joint and separate applications.* An effective strategy for maximizing the Medicaid participation of families who come into TANF offices is for states to make both joint and Medicaid-only applications available. This way, no matter what course a family takes with regard to seeking TANF assistance, the family can apply for Medicaid easily.

Administrative Strategies and Considerations

Effective implementation of the new Medicaid rules requires procedures that ensure that eligibility for Medicaid is considered when TANF assistance is provided, denied, delayed, or terminated. State procedures should assure that caseworkers are proactive in offering families the opportunity to apply. Families should not be expected to take the initiative to ask about Medicaid. Rather, all those who come to TANF offices should be asked about their health coverage needs and informed of the process for applying for Medicaid and CHIP. Following are suggestions for how to assure such an outcome:

- ✔ **Provide Medicaid and CHIP outreach to families at TANF sites.** The key to any effort to identify and enroll eligible children and families is outreach. Success in outreach and enrollment requires the involvement of TANF offices and personnel. Families who inquire about or apply for TANF should also receive information about Medicaid and CHIP, including how to apply for these programs. TANF agency staff should be trained to conduct this outreach and education.

- ✔ **Place Medicaid/CHIP workers in TANF offices.** States are encouraged to place Medicaid and CHIP eligibility workers at TANF offices to take applications and assist in their preparation. This practice is especially important at sites where, by state or local policy, low-income people are often directed to job searches, receive diversion payments, or otherwise receive assistance that may result in their not filling out an application for TANF assistance.

- ✔ **Conduct staff training.** States can send a strong and clear message to their employees about the importance of Medicaid and CHIP eligibility through special staff training, supervisor reviews, and other mechanisms. Such efforts should call attention to the differences between the TANF rules and Medicaid and CHIP eligibility rules, and to the procedures necessary to ensure that Medicaid and CHIP eligibility are considered. States should consider offering similar training to hospitals, clinics, health providers, child care centers, Head Start programs, WIC offices, community-based organizations, and other programs that come into contact with low-income families and children.

- ✔ **Encourage Medicaid application when the TANF application process halts.** States should ensure that the Medicaid application process is completed when a family does not qualify for TANF-funded assistance or abandons the TANF application process. It is important to inform families early in the application process about the different eligibility rules for TANF and Medicaid. Otherwise, families may not understand that even if they don't qualify for TANF, their Medicaid application can and should be processed and could well be approved.

  To give an example, a person who applies for TANF might be required to meet an up-front job search requirement before becoming eligible for cash assistance. Although that person's TANF application might be suspended, he or she should be guided to proceed with the application for Medicaid. As another illustration, a parent might not carry through with a joint application if he or she finds a job, thinking that the family is no longer eligible for Medicaid coverage. Rather than just accepting a withdrawal of a TANF-Medicaid application, a state should send a letter informing the family that all or some of its members might still be eligible for Medicaid, laying out the steps the family needs to take to complete the Medicaid aspects of the application, and urging them to pursue application.

- ✔ **Educate families.** Informing families early in the TANF application process and regularly thereafter about how the Medicaid and TANF rules differ, and reminding them that Medicaid eligibility is not tied to TANF receipt, can help encourage families to submit and complete Medicaid applications. One reason families may not sign up for Medicaid is that they are under the mistaken impression that Medicaid eligibility depends on welfare eligibility. Therefore, states should make clear in all of their informational materials about TANF that coverage under Medicaid and CHIP does not require welfare eligibility and that, no matter whether or not families apply for or receive TANF assistance, they are encouraged to apply for Medicaid and/or CHIP.

  For individuals facing language barriers, states should consider developing culturally-appropriate materials in languages other than English.

- ✔ **Simplify application and enrollment.** States have considerable flexibility under Medicaid and CHIP to simplify the application and enrollment processes. HCFA has provided states with suggestions on how to do so in a letter to state health officials dated September 10, 1998, which can be found on the HCFA website (*http://www.hcfa.gov*).

Many states have simplified their application and enrollment processes for children under Medicaid and CHIP by shortening application forms, allowing the use of mail-in applications, reducing or eliminating verification and documentation requirements that go beyond Federal requirements, and speeding up processing of applications. States should consider taking similar steps to simplify the application process for low-income families.

✔ **Coordinate TANF and Medicaid Section 1931 eligibility.** The alignment of TANF and Medicaid eligibility requirements for low-income families can greatly facilitate families' participation in Medicaid. Medicaid and TANF requirements can be aligned by taking advantage of the flexibility to modify financial methodologies and standards under Section 1931, loosen the deprivation requirements for two-parent families, and continue certain AFDC waivers. By exercising these options, states can provide automatic Medicaid eligibility for TANF recipients as they did for AFDC recipients prior to the enactment of welfare reform.

States have begun to take advantage of the flexibility to harmonize TANF and Medicaid eligibility in several ways. For example, several states have adopted earnings disregards in their TANF programs that are more generous than the old AFDC earnings disregards. To ensure that TANF recipients also qualify for Medicaid, many of these states have adopted the same disregards under the Section 1931 eligibility group. With the exception of earned income disregards, the financial rules under the Section 1931 group must be applied to all members of the group, including those families who do not receive TANF benefits.

✔ **Eliminate or ease the Medicaid resource test.** Most states have dropped the Medicaid resource test for children and now, under Section 1931, states have the ability to drop or ease the resource test for parents as well. Taking this step makes it easier to establish Medicaid eligibility, and can also make Medicaid rules more compatible with welfare reform initiatives. Some states that have not dropped their resource requirements under Section 1931 have made their resource rules less restrictive, for example, by exempting the value of a car.

Maintaining Coverage for Families Who Leave TANF Assistance

This chapter focuses on the statutory and regulatory requirements with which states must comply in providing Medicaid to adults and children in families leaving the welfare rolls. This chapter also identifies administrative practices that can increase the likelihood that parents and children who leave welfare will continue to receive Medicaid and/or CHIP.

State Requirements and Options under Federal Medicaid Law

A. Mandatory Eligibility Policies

- ✔ **Exhaust all avenues to eligibility before denial or termination.** Because Medicaid eligibility is not based on TANF eligibility, states may not deny Medicaid eligibility to a family or any family member simply because the family is ineligible for TANF because of employment, time limits, sanctions, or for any other reason. Nor can a state deny Medicaid eligibility because a family member loses eligibility under a particular Medicaid eligibility category. Further, it is not acceptable for a state to deny a joint application and then advise families to reapply if they think they may be eligible under another Medicaid category. *States are prohibited from denying or terminating Medicaid eligibility unless all possible avenues to Medicaid eligibility have been affirmatively explored and exhausted.*

  Since Medicaid eligibility for families no longer hinges on eligibility for welfare, and since Medicaid generally covers a broader group of children and families than may be eligible for TANF, some or all members of a family that fails to meet TANF eligibility criteria are likely to be eligible for Medicaid. There are many possible avenues to Medicaid eligibility for family members denied or terminated from TANF assistance, including the Section 1931 group (depending on family income and other state eligibility rules for the group), poverty-level groups, and transitional Medicaid.

- ✔ **Provide transitional Medicaid for families.** Under Section 1925 of the Social Security Act, states must provide extended Medicaid benefits ("transitional Medicaid") to families who, because of hours of work or income from employment (or loss of the earned income disregard), lose their

eligibility for Medicaid under the Section 1931 group. (States must also provide transitional Medicaid when eligibility would otherwise be lost due to child support income.) It is important to note that it is the loss of coverage under Section 1931 — not the loss of TANF assistance — that is now the trigger for transitional Medicaid.

States are required to provide an initial six-month period of transitional Medicaid and, subject to certain reporting requirements and the income limit explained below, can provide an additional six months of coverage. Some states provide a longer period of transitional Medicaid under Section 1115 waivers. (Four months of coverage are available when child support payments trigger eligibility.)

To be eligible for transitional Medicaid, a family must have received Medicaid under Section 1931 in three out of the preceding six months before becoming ineligible under this category. No income limit applies to families for the initial six-month period of transitional Medicaid. However, the optional second six-month period is limited to families whose earned income (less necessary child care expenses) does not exceed 185% of the Federal poverty level for the size of the family.

B. Optional Eligibility Policies

- ✔ **Provide continuous eligibility for children.** Under Section 1902(e)(12) of the Social Security Act, states may grant continuous Medicaid eligibility to children under age 19 for up to 12 months, even if there is a change in family income, assets, or composition. Such eligibility must end when the child reaches age 19. By granting children eligibility for up to one year without regard to changes in circumstances, states can minimize the burden on families seeking to maintain coverage for their children. Most importantly, continuous eligibility can minimize coverage losses among children that occur because families are in financial transition and because of the barriers to continued participation that recertification requirements impose. To adopt the continuous eligibility option, states must amend their Medicaid state plans. States may also grant continuous eligibility under CHIP.

- ✔ **Termination for failure to meet TANF work requirements.** States can terminate Medicaid coverage for a TANF recipient (excluding pregnant women and children eligible under a poverty-level group and minor children who are not heads-of-household under TANF) if the recipient's TANF assistance is terminated because of a refusal to cooperate with TANF work requirements. This sanction extends only to the person violating the TANF work requirement, in most cases the adult head-of-household. A state cannot terminate Medicaid benefits for other family members, including the chil-

dren of an adult who fails to meet a TANF work requirement. States that wish to adopt this option to terminate Medicaid for refusal to cooperate with work requirements must submit a Medicaid state plan amendment.

- ✔ **Medicaid payment of premiums and cost-sharing for employer-based health coverage.** Under Section 1906 of the Social Security Act, states have the option of paying a low-income worker's share of the premium for employer-sponsored health insurance along with any cost-sharing, if such action would be cost-effective relative to providing Medicaid for that person. That is, the cost to the state of the premiums and cost-sharing must not exceed the cost to the state of providing Medicaid benefits. The family or individual must be otherwise eligible for Medicaid and agree to enroll in the employer-based health insurance as a condition of Medicaid eligibility. Under Section 1925, states have the option of requiring that individuals receiving transitional Medicaid enroll in employer-sponsored insurance, whether or not it is cost-effective.

Administrative Strategies and Considerations

States may want to consider the following administrative strategies to maximize enrollment in Medicaid and CHIP:

- ✔ **Prevent inappropriate Medicaid denials and terminations.** The key to states ensuring that Medicaid-eligible families continue to receive Medicaid after their TANF benefits have been terminated is the set of procedures they use to prevent inappropriate Medicaid eligibility terminations. In no event should closure of a TANF case automatically result in closure of a Medicaid case.

  In many situations in which a TANF case is closed, the state will have all the information it needs to determine whether Medicaid eligibility for a family should continue; in these cases, the state must make the Medicaid redetermination without seeking additional information from the family. In other situations, families will need to be informed that they must provide additional information to allow the state to evaluate their ongoing Medicaid eligibility. One way states can help families understand that their Medicaid benefits are not affected by the actions taken in their TANF case is to make sure that TANF case-closing notices state this fact very clearly.

- ✔ **Educate families about transitional Medicaid.** To maximize the participation of families in transitional Medicaid, it is critical that states educate families about this benefit and the steps they need to take — such as reporting earnings, rather than closing their cases — to safeguard and facilitate their Medicaid eligibility when they leave TANF assistance.

- ✔ **Delink Medicaid and TANF redeterminations.** To avoid inappropriate Medicaid termination, states can establish different redetermination periods for Medicaid and TANF, thereby delinking Medicaid and TANF eligibility reviews. Under Medicaid regulations, states must conduct redeterminations at least every 12 months, or promptly upon notification of a change in the family's or child's circumstances that may affect eligibility (unless the state has adopted the 12-month continuous eligibility option for children, as described next).

- ✔ **Adopt continuous eligibility for children.** Under Section 1902(e)(12) of the Social Security Act, states may grant continuous Medicaid eligibility to children under age 19 for up to 12 months, even if there is a change in family income, assets, or composition. Such eligibility must end when the child reaches age 19. By granting children eligibility for up to one year without regard to changes in circumstances, states can minimize the burden on families seeking to maintain coverage for their children. Most importantly, continuous eligibility can minimize coverage losses among children that occur because families are in financial transition and because recertification requirements impose barriers to continued participation.

- ✔ **Simplify redeterminations.** Eligibility reviews can be simplified. To avoid time-consuming face-to-face meetings and help working parents avoid missing work, states can be kept informed of changes in family circumstances by telephone or mail. States can respond to requests for eligibility reviews by simplifying the review process, much as they have simplified their Medicaid applications for children. Redetermination forms can be shortened, most of the necessary information can be filled in by the state based on the information on hand, and the family can be asked to send in the signed form with any changes noted.

- ✔ **Review closed TANF cases.** A state review of TANF cases that have been closed and in which Medicaid was not continued may identify families likely to be eligible for Medicaid. States have the authority to re-open erroneously closed cases on their own motion, and should, at a minimum, conduct aggressive outreach to families in this situation.

- ✔ **Expand Medicaid coverage for low-income working families.** States have the flexibility to use less restrictive financial methodologies and standards under the Section 1931 group, as well as authority to loosen deprivation requirements, in order to expand Medicaid to cover more working families (see pages 6-7 for a detailed discussion of state flexibility). States adopting such policies provide health security — a critical support — to families who have made or are making the transition to self-sufficiency. When states take this route to broadening eligibility for Medicaid, families at the higher income levels remain eligible as long as their income does not exceed the Medicaid income threshold and they continue to meet other applicable requirements.

- ✔ **Improve the reach of transitional Medicaid.** To be eligible for transitional Medicaid, a family must have received Medicaid under Section 1931 in three out of the preceding six months before becoming ineligible under this category. The same flexibility under Section 1931 that states can use to expand coverage quite broadly (e.g., via income and asset disregards) can also be used for the narrower purpose of increasing access to transitional Medicaid for working families who may be diverted from TANF or leave TANF assistance in less than the three months typically required to trigger transitional Medicaid.

  For example, states that offer lump-sum "diversion" payments in lieu of recurring cash assistance can prevent these lump-sum payments from making the family ineligible for Medicaid by disregarding them as either income or resources when they determine eligibility under Section 1931. To give another example, a state can disregard all earnings below the poverty level for 12 months; this way, a low-income working family can obtain Medicaid eligibility under the Section 1931 group for 12 months, and subsequently qualify for transitional Medicaid for up to an additional 12 months. Alternatively, a state can adopt a more limited disregard of all earned income for three months, enabling families to obtain Medicaid eligibility under Section 1931 for the three-month period necessary for the family to qualify for transitional Medicaid.

  As the illustrations make clear, limited changes in Medicaid rules can ensure that families in the earliest stages of their connection to the workforce do not lose their Medicaid coverage. Such programmatic coordination is key to the development of a coherent state strategy for supporting families in transition.

- ✔ **Pay private health insurance premiums and cost-sharing.** States' use of the option to cover Medicaid-eligible working families by paying the family's share of premiums for employer-sponsored health insurance, along with deductibles, coinsurance, and other cost-sharing, gives families an incentive not to drop employer-sponsored insurance, preserving continuity in their health coverage and supporting their employment. The approach also builds on the private insurance system, and may result in savings to the state.

Reaching Families Outside the TANF System

This chapter deals with ways to ensure coverage for low-income families who do not come in contact with the TANF system. As states succeed in helping families move to self-sufficiency, more families will remain outside the welfare system. Thus, it is critical that new strategies for reaching families outside the TANF system be developed and implemented.

The longstanding linkage between cash assistance and Medicaid was often seen as an inequitable and counter-productive feature of the old system. When families learn that they can receive Medicaid coverage without having to receive welfare, they may be less likely to turn to welfare in the first place or to return to the welfare system in the event that they have significant health care needs. This chapter highlights the historic opportunity that the delinkage of Medicaid from welfare presents to promote Medicaid and CHIP coverage as a freestanding support for low-income families with children, and outlines approaches states can take toward this goal.

This chapter also emphasizes the importance of information and outreach efforts, and of simplifying the application and enrollment processes, as means of identifying and enrolling low-income families and children in Medicaid and CHIP.

State Requirements and Options under Federal Medicaid Law

A. Mandatory Eligibility Policies

✔ **Outstation eligibility workers.** Medicaid law and regulations require that states provide an opportunity for children under age 19 and pregnant women to apply for Medicaid at locations other than welfare offices. States are required to have outstationing arrangements at facilities designated as "disproportionate share hospitals" and Federally Qualified Health Centers (FQHCs). HCFA regulations (42 CFR 435.904) permit alternative outstationing arrangements under certain limited conditions, and allow states to use additional sites where children and pregnant women receive services. States are free to station Medicaid eligibility workers at any location to take applications, provide assistance, and, if authorized, evaluate applications and make eligibility determinations.

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B. Optional Eligibility Policies

✔ **Expand coverage for families under Section 1931.** Section 1931 authorizes states to use financial standards and methodologies for low-income families that are more generous than the standards and methodologies in AFDC state plans in effect on July 16, 1996. Together with the new flexibility to define deprivation (e.g., by substituting another definition of unemployment for the 100-hour rule), states can use Section 1931 to take two significant policy actions. (See pages 6-7 for a detailed discussion of state flexibility.) First, they can equalize their treatment of single- and two-parent families for Medicaid purposes. Second, they can expand coverage of families as far as state budget and policy preferences permit. States can accomplish these policy changes through amendments to their Medicaid state plan; they do not need to obtain Federal waivers.

Recognizing that Section 1931 coverage expansions will require additional state expenditures to draw down Federal matching payments (see under **Cover children under CHIP** regarding enhanced Federal match for uninsured children in families covered under a Section 1931 expansion), it should be noted that states' expansions of coverage to low-income families under Section 1931 can be as broad or as narrow as state resources and other considerations permit. For example, states can:

- ***Expand Medicaid to cover all families up to a specified income level.*** By using more generous financial methodologies and standards, states can expand coverage under Section 1931 to reach single- and two-parent families with more income than Medicaid has traditionally covered. Such expansions present an opportunity for states to recast and market Medicaid as a freestanding health insurance program for low-income families, improving the possibility of de-stigmatizing Medicaid and enhancing the potential of the program to reach families who do not come into contact with the TANF system. The law leaves states free to raise their effective income eligibility thresholds for Section 1931 to whatever level they wish.

- ***Phase in expansions.*** States can expand coverage under Section 1931 more narrowly initially and, based on their evaluation of the expansion and its success in meeting state welfare reform and health coverage objectives, consider broadening those expansions further to include families with more income and/or resources.

- ***Improve the reach of transitional Medicaid.*** The same flexibility under Section 1931 (e.g., income and asset disregards) that states can use to achieve a broad expansion of coverage can also be used for the narrower purpose of increasing access to transitional Medicaid for

families who do not come into contact with the TANF system. States can extend Medicaid to working families temporarily, by using income and asset disregards that permit families to obtain Medicaid eligibility for at least three months, and thus give them access to up to 12 months of transitional Medicaid as well. Such limited changes in Medicaid rules can ensure that families' success in attaining self-sufficiency does not preclude their qualifying for health coverage — a coherent result that supports the twin goals of reducing the numbers of people without insurance and supporting state welfare reform initiatives.

- ***Expand coverage to two-parent families.*** States can expand Medicaid to cover more two-parent families by replacing the 100-hour rule with a broader definition of unemployment.

✔ **Cover children under CHIP.** Under CHIP, enhanced matching funds are available to states to provide coverage for uninsured children who are not otherwise eligible for Medicaid. Coverage can be provided through a Medicaid expansion, a separate CHIP program, or a combination of both. Under Medicaid expansions, the usual Medicaid eligibility rules apply. Under a separate CHIP program, states have flexibility to establish eligibility requirements.

Nearly all states have approved CHIP plans and are implementing their programs. States should consider further expansions of coverage for uninsured children; such expansions promote both health care coverage and welfare reform goals by improving health security and providing needed support to low-income working families.

States implementing CHIP through a Medicaid expansion can claim enhanced Federal matching funds under Title XIX (section 1905(u)(2)(B)) for children who become eligible for coverage as a result of an expansion of family coverage under Section 1931. The enhanced match can be claimed only for uninsured children who would not have qualified for Medicaid coverage under the Medicaid state plan in effect on March 31, 1997. The funds claimed for CHIP-eligible children under Section 1931 would count against the state's CHIP allotment. To claim the enhanced match, states must have a means of identifying children who are uninsured and otherwise qualify for enhanced Federal matching payments for the medical assistance they receive. For children who do not meet the criteria for the enhanced match, the state may continue to claim its regular Medicaid match.

✔ **Cover families under CHIP.** CHIP also grants states the authority to obtain a "variance" to purchase family coverage that includes coverage of CHIP children if the state can demonstrate that the cost to the CHIP program of purchasing the family coverage does not exceed the cost of obtaining CHIP

coverage for the children alone, and that the family coverage will not otherwise substitute for other health insurance coverage for the children. While these statutory constraints limit use of the family coverage option under CHIP, a few states, including Massachusetts, have utilized this option to extend coverage to poor working families.

It should be noted that a CHIP family coverage program would not extend coverage to the parents of children who are eligible for Medicaid. To avoid an anomalous result in which higher income families are covered under CHIP, but the parents of lower-income children lack coverage, states would also need to implement a Medicaid expansion under Section 1931.

✔ **Presumptive eligibility for children and pregnant women.** States have the option to provide presumptive Medicaid eligibility to children and to pregnant women. Under Section 1920A of the Social Security Act, certain entities can determine, based on preliminary information, whether the family income of a child is within the state's income eligibility limits for Medicaid. If it is, the child (or, under Section 1920 the pregnant woman) can be granted temporary eligibility for Medicaid and has until the end of the following month to submit a full Medicaid application. A similar approach may be used under a separate CHIP program. It should be noted that states that use a simplified Medicaid application can also use this form to establish presumptive eligibility, eliminating the need for a two-step application. As always, however, an authorized state employee must make the Medicaid eligibility determination.

Presumptive eligibility provides the opportunity to grant immediate health care coverage without first requiring a full Medicaid eligibility determination. This option also offers the advantage of providing additional "entry points" into the Medicaid system because health care providers and others can grant temporary coverage on the spot when children and pregnant women go to receive health care services and other forms of assistance.

Under the law, the entities that can establish presumptive eligibility for children include: Medicaid providers, entities that determine eligibility for Head Start, WIC, and child care subsidies under the Child Care and Development Block Grant, and other entities designated by the state. Presumptive eligibility for pregnant women can be established by specified entities likely to have contact with pregnant women seeking pregnancy-related services. While TANF offices are not specifically mentioned in the statute, TANF offices can establish presumptive eligibility if they determine eligibility for one of the programs listed.

- ✔ **Continuous eligibility for children.** Under Section 1902(e)(12) of the Social Security Act, states may grant continuous Medicaid eligibility to children under age 19 for up to 12 months, even if there is a change in family income, assets, or composition. Such eligibility must end when the child reaches age 19. By granting children eligibility for up to one year without regard to changes in circumstances, states can minimize the burden on families seeking to maintain coverage for their children. Most importantly, continuous eligibility can minimize coverage losses among children that occur because families are in financial transition and because recertification requirements impose barriers to continued participation.

Administrative Strategies and Considerations

States may want to consider some or all of the following administrative strategies and other measures to improve outreach and increase coverage of low-income families with children:

- ✔ **Create application sites outside the welfare office.** States may make Medicaid applications regularly available at sites outside of welfare offices. For example, sites can be established at state or county offices that handle child care subsidies or at "Medicaid-only" offices. States may also place eligibility workers at locations that provide services to low-income families (see just below) subject to the regulations on outstationing cited on page 19. Federal law does not limit states' options along these lines as long as all final eligibility determinations are performed by state personnel who are authorized by the state to perform these functions. This approach can help promote the program as one that offers health insurance coverage to low-income families, generally, and not just to families receiving TANF.

- ✔ **Place Medicaid and CHIP eligibility workers in communities.** The opportunity to apply for Medicaid or CHIP can be enhanced by placing outreach and eligibility workers in locations where they are likely to interact with low-income families who are eligible for those programs (e.g., hospitals, community and migrant health centers, community action agencies, schools, community colleges, Head Start programs, and one-stop career centers).

  Medicaid permits only authorized state eligibility workers to evaluate the information on the application and supporting documentation and to make eligibility determinations. But other individuals, including volunteers, provider and contractor employees and TANF workers may take applications at the outstation locations described on page 19, and perform initial processing activities, including interactions with applicants. The regulations on outstationing do not prohibit the use of volunteers to help appli-

cants complete applications at sites other than outstation locations. Therefore, states can work with a very broad range of public and private organizations to identify eligible families, educate them about Medicaid and CHIP, and have them complete applications for health insurance. Again, the evaluation of Medicaid application information and the eligibility determination itself must be performed by state personnel who are authorized by the state to perform these functions.

States have greater flexibility to determine the sites where non-Medicaid CHIP applications may be taken and who may conduct initial application processing activities and make eligibility determinations.

✔ **Improve the availability of application sites.** It is important that states make it easy for low-income families, including working families, to apply for Medicaid and CHIP. Keeping application sites open during evening hours and on weekends makes it more convenient for working families to apply.

✔ **Simplify the application and enrollment processes.** Application and enrollment processes should not be a barrier to low-income families applying for Medicaid. As noted earlier, states have taken several steps to simplify the application and enrollment process for children under Medicaid and CHIP, including simplifying application forms, reducing documentation requirements, allowing mail-in applications, and expediting processing of applications. States also should consider allowing families who are not applying for TANF to use simplified Medicaid and CHIP applications and application processes. This approach would facilitate Medicaid and CHIP participation among these families. (HCFA's guidance on simplifying the Medicaid and CHIP application and enrollment processes was provided in a letter to state health officials dated September 10, 1998, which can be found on the HCFA website (http://www.hcfa.gov).)

✔ **Educate families.** It is important that low-income families understand that the coverage available under Medicaid and CHIP for families and children is not linked to receipt of TANF assistance. The misconception that Medicaid eligibility is linked to TANF is widespread. Vigorous educational efforts are needed to correct this belief so that enrollment in Medicaid and CHIP can be maximized.

✔ **Conduct outreach.** It is critical that aggressive outreach be conducted to provide Medicaid and CHIP information to low-income families. States have used a variety of valuable approaches to help them locate children and facilitate their enrollment in Medicaid and CHIP, which should also be used to reach out to low-income families as a whole. They include:

- implementing a toll-free telephone hotline for enrollment information;
- placing billboards and posters in places frequented by low-income families;
- producing public service announcements for radio and television;
- distributing information through other public and private programs designed for low-income families (e.g., child care, Head Start, food pantries, one-stop centers, and community-based organizations);
- stationing state eligibility workers in places frequented by low-income families, such as TANF offices, WIC offices, hospitals, and one-stop centers); and.
- working with local community-based organizations to develop creative outreach programs.

States should also maximize publication of the national toll-free number that automatically connects callers with the CHIP program in their state. The number is 1-877-KIDS-NOW.

✔ **Integrate health and social service systems.** States should aim to integrate their programs to ensure that low-income families receiving any of an array of services learn about and apply for Medicaid and CHIP. The recently enacted Workforce Investment Act (WIA) promoted this concept by establishing an innovative "one-stop" system designed to provide a comprehensive array of job training, education, and employment services at a single neighborhood center. The WIA specifies several Federal programs and activities that must participate in each local one-stop system. Although not required partners, the TANF and Medicaid programs can link up with one-stop systems as optional partners, enhancing the support available to low-income working families and families making the transition from welfare to self-sufficiency.

Several states have taken advantage of this new opportunity. For example, the Kenosha County Job Center in Wisconsin has combined services, including Medicaid, at its job center. Although the one-stop center was initially designed to include services fairly directly related to job training, job-seeking, and education, it evolved to include Medicaid, child support, child care, and Head Start.

Funding Opportunities

This chapter sets out the funding sources available under Medicaid, CHIP, and TANF for outreach activities, systems changes, training, and other investments critical to supporting compliance with Medicaid requirements in the new welfare context and to maximizing health care coverage of low-income families with children. States have several options for claiming Federal matching funds for their spending on efforts to find and enroll families and children in Medicaid and CHIP. The Medicaid and CHIP funds for outreach were described in detail in a January 23, 1998 letter to state health officials (available at http://www.hcfa.gov) highlighting new and existing opportunities for outreach to uninsured children. In addition, options to receive Federal funds for outreach spending are available under TANF. These options are described below.

Medicaid Funds

Medicaid law does not limit the amount of money a state can spend on outreach efforts to enroll people in Medicaid. The Federal government will match such spending dollar for dollar. In addition, a special $500 million Medicaid fund was created under the welfare reform law to help states with the additional administrative costs of eligibility determinations resulting from the delinkage of Medicaid from welfare eligibility and the establishment of Section 1931. These funds are available for matching certain allowable administrative expenditures incurred by states during the first three years in which the states' TANF programs are in effect. State spending is matched by the Federal government at either a 90 percent or a 75 percent rate. (For more details, see the notice published in the Federal Register on May 14, 1997, Vol. 62, No. 93, pages 26545-26550.)

Each state has an allocation from the $500 million fund from which it can claim matching funds. Each state's allocation is composed of a "base allocation" and a "secondary allocation." The base allocation for each state is $2 million; the secondary allocation varies by state based on state-specific factors. Federal matching funds are available from the base allocation at the enhanced matching rate of 90 percent for allowable administrative activities (including outreach), regardless of the type of activity. Federal matching funds are available from the secondary allocation at enhanced matching rates of either 90 percent or 75 percent, depending on the type of activity. Activities whose costs are claimable from the secondary allocation at the enhanced rate of 90 percent include: educational activities, public service announcements, outstationing of eligibility workers, training, outreach, developing and disseminating new publications, and local community activities. Activities whose costs

are claimable from the secondary allocation at the enhanced rate of 75 percent include: hiring new eligibility workers, designing new eligibility forms, identifying at-risk TANF recipients, intergovernmental activities, and eligibility systems changes.

In order to be allowable, activities must be attributable to administrative costs of eligibility determinations that are incurred due to the enactment of Section 1931. However, it is clear that outreach efforts conducted by states to implement the provisions of Section 1931 may also result in Medicaid eligibility determination activities for individuals covered under other groups. It is neither administratively efficient nor practical, with respect to claims for Section 1931 outreach activities, to distinguish between activities resulting in eligibility determination under Section 1931 and activities related to Medicaid eligibility under other statutory authorities. Therefore, so long as the outreach activities are designed principally to address the eligibility determinations related to Section 1931, states may claim the costs of such activities at the enhanced Federal matching rate.

CHIP Funds

State spending on CHIP-related outreach activities is matched from the state's CHIP allotment. States may spend up to 10 percent of their total CHIP expenditures (Federal and state) on non-benefit activities, including outreach. These expenditures are matched at the enhanced CHIP matching rate. At state option, outreach activities related to a CHIP Medicaid expansion can be matched either from the state's CHIP allotment (at the CHIP enhanced matching rate) or at the regular Medicaid administrative matching rate. If a state elects to claim the CHIP match rate for outreach expenditures related to the CHIP Medicaid expansion, then the Federal matching payments count against 10 percent limit and the CHIP allotment. If the state exceeds either limit, it may claim matching for the additional costs of these activities at the regular administrative matching rate under the Medicaid program.

TANF Funds

States can also use their Federal TANF or state maintenance-of-effort (MOE) funds for outreach and training activities for Medicaid and CHIP. However, MOE funds cannot be used as state Medicaid matching funds. While Section 408(a)(6) of the Social Security Act prohibits the use of Federal TANF funds to provide medical services (except for pre-pregnancy family planning services), TANF funds can be used for non-medical services, such as outreach to ensure medical coverage.

Over the past several years, cash assistance rules have changed at both the Federal and State levels. As a result of these changes to promote work and responsibility, and a strengthened economy, many fewer families are receiving cash assistance. When eligibility for cash assistance and Medicaid were delinked, Congress and the Administration took specific actions to assure that Federal law continued to guarantee Medicaid eligibility for children and families who formerly qualified for Medicaid through their receipt of cash assistance.

These changes required a significant retooling of Medicaid eligibility rules and procedures at the State and local level. In some cases, it appears that necessary adjustments to State and/or local policies, systems and procedures have not been made.

Several States have taken action to reinstate coverage for families and children who have been terminated improperly from Medicaid. Reinstatement is compelled by Federal regulations and prior court decisions. Under Federal regulation 42 CFR 435.930, States have a continuing obligation to provide Medicaid to all persons who have not been properly determined ineligible for Medicaid. This includes individuals whose Medicaid has been terminated through computer error or without a proper redetermination of eligibility. Therefore, all States must take steps to identify individuals who have been terminated improperly from Medicaid and reinstate them, as described below.

Identifying Improper Actions

A. Requirements for TANF-related terminations
States must determine whether individuals and families lost Medicaid coverage when their TANF case was closed, or when their TMA coverage period ended without a proper notice or without a proper Medicaid redetermination, including an ex parte review consistent with previous guidance. For example, States should review whether their computer system improperly terminated Medicaid coverage when TANF benefits were terminated, and they should consider whether families whose TANF termination was due to earnings were evaluated with respect to ongoing Medicaid eligibility, including TMA. In addition, if a State did not implement its Section 1931 category until some time after its TANF program went into effect, the State must review Medicaid/TANF terminations that occurred before the State had an operative Section 1931 category.

B. Requirements for terminations of disabled children eligible for Medicaid under Section 4913 of the Balanced Budget Act of 1997
Children who became ineligible for SSI due to the 1996 change in the SSI disability rules and then were terminated from Medicaid either without adequate consideration of their eligibility under Section 4913 of the BBA, or without a proper redetermination, including an ex parte review consistent with previous guidance, must be identified and reinstated. States must compare the Social Security Administration (SSA) list of children whose Medicaid eligibility was protected by Section 4913 and determine which, if any, of those children are not currently receiving Medicaid or are receiving Medicaid but are not identified as a Section 4913 child. The

Health Care Financing Administration (HCFA) and SSA will work with States to ensure that States have the information that they need to identify Section 4913 children. The results of these cross-matches should be promptly reported to the HCFA Regional Office.

C. Improper Denials of Eligibility

In some States, eligible individuals applying for both Medicaid and TANF may have been denied Medicaid improperly because eligibility determinations continued to be linked. While HCFA is not requiring States to identify and enroll these applicants, we encourage you to do so.

Reinstatement

If, after a State-wide examination of enrollment policies and practices, it appears that there have been improper terminations since their TANF plan went into effect, States must develop a timetable for reinstating coverage and conducting follow-up eligibility reviews as appropriate. Action to reinstate coverage should be taken as quickly as possible, and States should keep their HCFA regional office informed as they review their policies and practices and develop their plans. This guidance should not delay State actions to reinstate individuals that are already under way.

Because it may not always be clear or easy for the State to determine whether a particular individual was terminated properly, States that determine that problems in policy or practice did cause individuals to lose Medicaid improperly may reinstate coverage without making a specific finding that an individual termination was in fact improper. Such action is consistent with Federal regulations that require that eligibility be determined in a manner consistent with simplicity of administration and the best interests of the applicant or recipient (42 CFR 435.902).

Federal Financial Participation (FFP) will be available for up to 120 days of coverage after reinstatement, pending a redetermination of ongoing eligibility, regardless of the outcome of the redetermination process. States that have developed reinstatement procedures have typically reinstated individuals and families for a period of 60 or 90 days. Coverage provided during this time period will not be considered for any Medicaid Eligibility Quality Control (MEQC) purpose.

If a State determines that there have been no instances of improper terminations, it should inform the Regional Office of the review undertaken and the basis for its conclusions. HCFA will provide assistance to States throughout this process.

Contacting Individuals and Families

States may have to reinstate individuals and families who have not been in contact with the Medicaid agency for some time, and should take all reasonable steps to identify the individual or family's current address. For example, States could check Food Stamp program records for a more up-to-date address and alert caseworkers to the list of affected individuals so that these individuals are identified if they contact the agency for other reasons. Other outreach efforts might include notices to families receiving child care services and television and radio spots.

Redetermining Eligibility Once Reinstatement is Accomplished
In most situations, States will need to redetermine eligibility after reinstatement to assess whether the family or individual is currently eligible for Medicaid. To ensure that families understand the process and have adequate time to respond to requests for further information,

States should allow a reasonable time for the review process. As noted above, FFP will be available for up to 120 days after reinstatement to allow States adequate time to review ongoing eligibility.

Individuals and families whose most recent Medicaid eligibility determination or redetermination occurred less than 12 months before reinstatement may be continued on Medicaid until 12 months from the date of that last eligibility review, without any new redetermination of eligibility. In these situations FFP will not be limited to 120 days. Individuals and families who have earnings may be covered under TMA and therefore would be subject to the State's TMA reporting and review procedures.

When States redetermine the eligibility of children identified by SSA as a Section 4913 child, the child does not lose protection under Section 4913 because of a prior break in eligibility. Continuous eligibility is not a requirement of Section 4913.

Covering Services Provided Prior to Reinstatement
Many of the individuals and families who were terminated improperly will have incurred medical expenses that would have been covered under Medicaid. States have the option to provide payment to providers and individuals for the cost of services covered under the State's Medicaid plan provided between the time the individual was terminated from Medicaid and reinstatement. FFP will be available to States that provide such retroactive payments, including direct payments by the State to individuals who had out-of-pocket costs for services that would have been covered by Medicaid had the individual not been terminated from the program. FFP in direct payments will be based on the full payment amount. FFP in payments to participating Medicaid providers will be at the Medicaid rate.

Review of Federal Requirements for Eligibility Redeterminations
Over the past few years, HCFA has issued guidance on the redetermination process (see letters issued February 6, 1997, April 22, 1997, November 13, 1997, June 5, 1998 and March 22, 1999). This guidance instructs States that individuals must not be terminated from Medicaid unless the State has affirmatively explored and exhausted all possible avenues to eligibility. It also outlines requirements for ex parte reviews. However, recent reports indicate that inadequate redetermination procedures have caused some eligible individuals and families to lose coverage, and some States have asked for more guidance in this area. As such, this letter restates and clarifies the previous guidance on (1) information that can be required at redeterminations; (2) ex parte reviews; and (3) exhausting all possible avenues of eligibility.

Information Required at Redeterminations
Pursuant to Federal regulations (42 CFR 435.902 and 435.916), States must limit the scope of redeterminations to information that is necessary to determine ongoing eligibility and that relates to circumstances that are subject to change, such as income and residency. States cannot require individuals to provide information that is not relevant to their ongoing eligibility, or that has already been provided with respect to an eligibility factor that is not subject to change, such as date of birth or United States citizenship.

Questions about the proper scope of a redetermination also arise when an individual reports a change in circumstances before the next regularly scheduled redetermination. Federal regulations require a prompt redetermination in such cases, but States may limit their review to eligibility factors affected by the changed circumstances and wait until the next redetermination to consider other factors. For example, if a State generally conducts a redetermination every 12 months and a parent reports new earnings three months after the family's most recent redetermination, the State must assess whether the individuals in the family continue to be eligible for Medicaid in light of the new earnings. However, it may wait until the next regularly scheduled redetermination to consider other eligibility factors.

Ex Parte Reviews
States are required to conduct ex parte reviews of ongoing eligibility to the extent possible, as stated in HCFA's previous guidance. By relying on information available to the State Medicaid agency, States can avoid unnecessary and repetitive requests for information from families that can add to administrative burdens, make it difficult for individuals and families to retain coverage, and cause eligible individuals and families to lose coverage. States should use the following guidelines and enclosed questions and answers in conducting redeterminations.

Program records. States must make all reasonable efforts to obtain relevant information from Medicaid files and other sources (subject to confidentiality requirements) in order to conduct ex parte reviews. States generally have ready access to Food Stamp and TANF records, wage and payment information, information from SSA through the SDX or BENDEX systems, or State child care or child support files.

Family records. States must consider records in the individual's name as well as records of immediate family members who live with that individual if their names are known to the State. Again, this should be done in compliance with privacy laws and regulations.

Accuracy of information. States must rely on information that is available and that the State considers to be accurate. Information that the State or Federal government currently relies on to provide benefits under other programs, such as TANF, Food Stamps or SSI, should be considered accurate to the extent that those programs require regular redeterminations of eligibility and prompt reporting of changes in circumstances. Even if benefits are no longer being provided under another program, information from that program should be relied on for purposes

of Medicaid ex parte reviews as long as the information was obtained within the State's time period for conducting Medicaid redeterminations unless the State has reason to believe the information is no longer accurate.

Timing of redetermination. States have the option to schedule the next Medicaid redetermination based on either the date of the ex parte review or the date of the last eligibility review by the program whose information the State relied on for the ex parte review. Since the date of the ex parte review will be the later of the two dates, States could reduce their administrative burden by scheduling the next redetermination based on the ex parte review date.

Use of eligibility determinations in other programs. The responsibility for making Medicaid eligibility determinations is generally limited to the State Medicaid agency or the State agency administering the TANF program. However, the State may accept the determination of other programs about particular eligibility requirements and decide eligibility in light of all relevant eligibility requirements.

Obtaining information from individuals. If ongoing eligibility cannot be established through ex parte review, or the ex parte review suggests that the individual may no longer be eligible for Medicaid, the State must provide the individual a reasonable opportunity to present additional or new information before issuing a notice of termination.

Exhausting All Possible Avenues of Eligibility

The Medicaid program has numerous and sometimes overlapping eligibility categories. For eligibility redeterminations, States must have systems and processes in place that explore and exhaust all possible avenues of eligibility. These systems and processes must first consider whether the individual continues to be eligible under the current category of eligibility and, in the case of a negative finding, explore eligibility under other possible eligibility categories.
The extent to which and the manner in which other possible categories must be explored will depend on the circumstances of the case and the information available to the State. If the ex parte review does not suggest eligibility under another category, the State must provide the individual a reasonable opportunity to provide information to establish continued eligibility. As part of this process, the State will need to explain the potential bases for Medicaid eligibility (such as disability or pregnancy).

In addition, in States with separate SCHIP programs, children who become ineligible for Medicaid are likely to be eligible for coverage in SCHIP. States should develop systems for ensuring that these children are evaluated and enrolled in SCHIP, as appropriate. As is consistent with the statutory requirements, States must coordinate Medicaid and SCHIP coverage.

Computerized Eligibility Systems

Changes in eligibility rules affecting cash assistance and Medicaid have required States with computerized eligibility systems to modify their computer-based systems. If a State has not

modified its system properly, some applicants may be erroneously denied enrollment in Medicaid. In addition, some beneficiaries may lose coverage even though they still may be eligible.

States have an obligation under Federal law to ensure that their computer systems are not improperly denying enrollment in, or terminating persons from, Medicaid. The attached questions and answers explain this obligation and present some practical suggestions on how States might meet their responsibilities under the law.

Conclusion

Most States are addressing the challenges associated with changing eligibility rules and systems, and many have developed promising new strategies for ensuring that children and families who are not receiving cash assistance are properly evaluated for Medicaid. HCFA will work with States as they assess the need for reinstatement, provide technical assistance to States implementing reinstatements, and facilitate exchanges among States to promote best practices to improve and streamline redetermination procedures. We anticipate that there will be many questions about the reinstatement process and the redetermination guidelines. We will make every effort to address your questions promptly, and to post and maintain a set of questions and answers on HCFA's website so that all States will be aware of how particular situations should be handled.

As important as it is to correct problems that have led eligible children and families to lose coverage, it is equally important that we improve eligibility redetermination processes and computer systems to prevent problems in the future. We are committed to working with you to implement this guidance to help achieve our mutual goal of an efficient, effective Medicaid program that helps all eligible families. If you have any questions concerning this letter, please contact your regional office.

Sincerely,
/s/
Timothy M. Westmoreland
Director
Attachment
cc:
All HCFA Regional Administrators
All HCFA Associate Regional Administrators For Medicaid and State Operations
Lee Partridge - Director, Health Policy Unit, American Public Human Services Association
Joy Wilson - Director, Health Committee, National Conference of State Legislatures
Matt Salo - Director of Health Legislation, National Governors' Association Director

QUESTIONS AND ANSWERS

Redeterminations

Q. When should a State rely on information available through other program records?
A. States must rely on all information that is reasonably available and that the State considers to be accurate. Information that the State or Federal government is relying on to provide benefits under other programs, such as TANF, Food Stamps or SSI, should be considered accurate to the extent that those programs require regular redeterminations of eligibility and prompt reporting of changes in circumstances. For example, in the Food Stamp program, Federal law requires States to recertify eligibility on a regular basis, and individuals receiving food stamps are required to report promptly any change in their circumstances that would affect eligibility. Thus, information in Food Stamp files of individuals currently receiving food stamp benefits should be considered accurate for purposes of Medicaid ex parte reviews.

Q. If benefits are no longer being paid under another program, can information from that program be relied on for purposes of Medicaid ex parte reviews?
A. It can be relied on if the information was obtained within the time period established by the State for conducting Medicaid redeterminations unless the State has reason to believe the information is no longer accurate. For example, take the case of a State that normally schedules Medicaid redeterminations every 12 months. If a child was determined financially eligible for SSI in January, 2000 and then loses SSI on disability-related grounds in March, 2000, the SSA financial information should still be considered accurate when the State redetermines Medicaid eligibility in March, 2000.

Q. When can the State schedule the next Medicaid redetermination if it relies on information from another program for its ex parte review?
A. The State may schedule the next Medicaid redetermination based on the date of the ex parte review or the date when the last review of eligibility was conducted in the other program. For example, consider a State that normally schedules Medicaid redeterminations every six months and that determines, based on a Medicaid ex parte review in March, that the family continues to be eligible for Medicaid. If the ex parte review relies on Food Stamp program information, and the last Food Stamp review took place in January, the State may wait until September (six months from March) to schedule its next Medicaid redetermination review, or it may schedule the next redetermination in June (six months after the last Food Stamp recertification).

Q. When can Medicaid accept another program's eligibility requirement determination?
A. When an eligibility requirement under another program applies equally to the Medicaid program, the State may accept the other program's determination with respect to this particular eligibility requirement. For example, if the resource standard and method for determining countable assets under the State's TANF program were the same or more restrictive than the asset rules in the Medicaid program, the Medicaid agency may accept TANF agency's determination that a family's assets fall below the Medicaid asset standard without any further assessment on it own part regarding this requirement. The Medicaid agency would then proceed to make a final determination of eligibility in light of all relevant eligibility requirements.

Q. When an individual reports a change in circumstances before the next regularly scheduled redetermination, must the State conduct a full redetermination at that time?
A. No. The State may limit this redetermination to those eligibility factors that are affected by the changed circumstances and wait until the next regularly scheduled redetermination to consider other eligibility factors. For example, if a State generally conducts a redetermination every 12 months and a parent reports new earnings three months after the family's most recent redetermination, the State must assess whether the individuals in the family continue to be eligible for Medicaid in light of the new earnings. However, it may wait until the next regularly scheduled redetermination to consider other eligibility factors.
Whether the State conducts a full or limited redetermination when an individual reports a change in circumstance, Federal regulations require that the redetermination must be done promptly.

Q. How must the State proceed to consider all possible avenues of eligibility before terminating (or denying) eligibility?
A. The systems and processes used by the State must first consider whether the individual continues to be eligible under the current category of eligibility and, if not, explore eligibility under other possible categories. The extent to which and manner in which other possible categories must be explored will depend on the circumstances of the case and the information available to the State.

For example, if the State has information in its Medicaid files (or other available program files) suggesting an individual is no longer eligible under the poverty-level category but potentially may be eligible on some other basis (e.g., under the disability or pregnancy category), the State should consider eligibility under that category on an ex parte basis. If the ex parte review does not suggest eligibility under another category, the State must provide the individual a reasonable opportunity to provide information to establish continued eligibility. As part of this process, the State will need to explain the potential bases for Medicaid eligibility (such as disability or pregnancy).

Q. If a State has determined that an individual is no longer eligible under the original category of coverage, does the State have the option to terminate coverage and advise the individual that he or she may be eligible under other categories and could reapply for Medicaid?
A. No. States must affirmatively explore all categories of eligibility before it acts to terminate Medicaid coverage.

Q. Does this requirement to explore all categories of coverage apply to Transitional Medical Assistance? When the TMA period is over, can the State terminate coverage and advise the family to reapply for Medicaid?
A. No. TMA is like any other Medicaid eligibility category. Eligibility under other categories of coverage must be explored before coverage is terminated. In light of expansions in coverage, particularly for children, many children in families receiving TMA will continue to be eligible under other eligibility categories.

Computer Systems

Q. My State's computer system may be erroneously terminating Medicaid coverage when families leave cash assistance. Because of Y2K, programming on a number of priorities has been backed up. The delinking reprogramming is scheduled to take place this fall. Is this an acceptable corrective action?

A. No. HCFA recognizes that Y2K delayed other priorities, and we know that it takes time to make computer changes. However, States have an obligation to move expeditiously to correct computer programming problems that are leading to erroneous Medicaid denials and terminations. HCFA will be working with States to correct computer problems and will provide whatever assistance we can to help resolve the problem.

In the meantime, no person should be denied Medicaid inappropriately due to computer error, and no person should have his/her Medicaid coverage terminated erroneously due to computer error. Once a problem with a State's computerized eligibility system has been identified, the State must take immediate action to correct the problem. If programming changes cannot be made immediately, an interim system to override computer errors must be put in place to ensure that eligible individuals are not denied or losing Medicaid.

HCFA will review State procedures and State plans to adopt new procedures as follow-up to the Medicaid/TANF State reviews.

Q. Have other States experienced these problems? How have they corrected the problems?

A. Each State's issues and processes are unique. The measures that will be effective to remedy computer-based problems will vary from State to State. There are a number of ways States can address these issues:

Correct the Computer Error - The most direct way to remedy the problem is by making the necessary changes to the computer system. This should occur expeditiously.

Implement an Effective Back-Up System to Prevent Erroneous Actions- While corrections to the computer system are being made, States must ensure that erroneous actions do not occur. States that have identified computer-based problems in their systems have adopted different approaches; four different approaches are described below. In each case, the State adopted a formal and systematic approach to correcting computer-based errors. A simple instruction to workers to override or work around computer errors is insufficient to ensure that erroneous denials and terminations will not occur.

Supervisory review - To stop erroneous terminations from occurring due to Medicaid/TANF delinking problems, Pennsylvania required supervisors to review all TANF case closures before any Medicaid termination could proceed. Having trained supervisors review terminations (and denials) can prevent wrongful terminations (and denials) from occurring.

Centralized review - Maryland instituted a system in which local supervisors and a State-level task force review all Medicaid denials and terminations that coincide with a TANF denial or termination. This system has been instrumental in ensuring that thousands of eligible families were not denied or terminated from Medicaid while computer fixes were finalized.

"Peremptory" reinstatement - The State of Washington devised a system in which cases to be terminated were given a next-day audit by caseworkers and managers. Cases that continue to be eligible for Medicaid are 'reinstated' before the case is scheduled to be closed.

Interim hold on case actions - A short-term moratorium on Medicaid case closings based on certain computer codes pending implementation of other solutions might be an option for some States. Medicaid case closings could be held as long as Federal requirements on the frequency of redeterminations are met.

Q. Are there any actions that States must take before they alter their computer systems?
A. Yes. In general, prior authorization from HCFA must be obtained in order for a State to receive federal matching funds for changes it makes to its computer systems. HCFA will work with States and provide technical assistance as early in the planning process as possible in an effort to help States accomplish their objective.

Q. Is there additional funding available to help with the changes in the computer system?
A. Yes. Per our letter of January 6, 2000 concerning the $500 million federal fund established in 1996, there is federal funding available for computer modifications related to delinking. We encourage you to review that letter and the amount your State has available from the enhanced matching funds to make changes needed as a result of the enactment of Section 1931 (the delinking provision). MMIS enhanced funding may also be available for some MMIS changes; please consult with your regional office.

COMMUNICATIONS

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
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Feather O. Houstoun
Secretary

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SEP 11 2000

The Honorable William V. Roth
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Roth:

We ask that the attached letter addressed to Mr. David Long, Regional Inspector General for Audit Services for the Department of Health and Human Services, be submitted for the record as part of the September 6, 2000, Finance Committee's hearing on the use of Medicaid funds. The letter is in response to the Department's report entitled "Review of the Commonwealth of Pennsylvania's Use of Intergovernmental Transfers to Finance Medicaid Supplementation Payments to County Nursing Facilities."

Sincerely,

Feather O. Houstoun

Feather O. Houstoun

Attachment

C: The Honorable Robert Bittenbender
Ms. Ann Spishock
Ms. Helen Herd
Ms. Becky Halkias
Mr. Russ McDaid

COMMONWEALTH OF PENNSYLVANIA
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AUG 3 0 2000

Michael Stauffer
Deputy Secretary for Administration

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Mr. David M. Long
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
150 South Independence Mall West / Suite 316
Philadelphia, Pennsylvania 19106-3499

Dear Mr. Long:

This is in response to your letter of August 23, 2000 in which you transmitted your draft report, #CIN A-03-00-00203, entitled "Review of the Commonwealth of Pennsylvania's Use of Intergovernmental Transfers to Finance Medicaid Supplementation Payments to County Nursing Facilities." Although given but seven days to reply to a report that took over three months to prepare, even a cursory reading discloses an unmistakable and unacceptable bias by your office regarding the Commonwealth's utilization of the federally authorized and, in our case, preapproved intergovernmental transfers (IGTs). Regrettably, your draft report, in its best light, can charitably be described as reflecting a fundamental misperception of the purpose behind the IGT program, along with a grossly negligent presentation of the facts relating to Pennsylvania's IGTs.

I. IGTS RESULTED FROM UNFUNDED MEDICAID MANDATES

Your report proceeds from the false and unsupported premise that IGTs are being used "to circumvent the Medicaid program requirement" of shared expenditures. On the contrary, the Health Care Financing Administration (HCFA) has been a full partner in the IGT program from its inception in the early 1990's. Current and past federal administrations have promoted the expansion of the Medicaid program as part of their legislative agenda. IGTs have been utilized to secure state acquiescence to the increased costs imposed on state taxpayers through these new and unfunded federal mandates.

The Medicaid program, though originally enacted to serve the poor, has now evolved to the point where it is actually several different programs serving very different populations. While the core program still provides medical services to the indigent, the long-term care program is now firmly established as one that substantially benefits the middle class. Every citizen in America today, no matter how affluent, can qualify for Medicaid to pay for nursing home care after three years. In addition to the expansion of long-term care services, children have a legal entitlement to the most technologically advanced, medically necessary services through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Recipients who receive Medicaid through managed care providers already have the protections of an extensive patient bill of rights. Today, the Medicaid program is effectively being used as a bridge to the ultimate goal of some form of universal health care coverage. In the meantime, states are expected to fund the increased costs of these program improvements with no additional help from the federal government.

The states' use of IGTs to help offset the costs of unfunded mandates imposed by Congress in Medicaid is well documented, and neither the Office of Inspector General (OIG) nor the HCFA can express surprise at what the states are doing. As a result of negotiations with the National Governors Association, Congress enacted the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, which specifically prohibited the HCFA from unilaterally changing the IGT program. IGTs, and other financing mechanisms, were studied by the General Accounting Office (GAO) in an August 1994 report by the GAO. See States Use Illusory Approaches to Shift Program Costs to the Federal Government (GAO/HEHS-94-133). Congress held hearings relating to these funding mechanisms in 1995 and the GAO issued a follow-up letter report to the House Budget Committee in May 1995. See Michigan Financing Arrangements (GAO/HEHS-95-146R). Throughout this process, the rationale for continuation of the IGT program was the need to provide some relief to the states for the escalating costs of Medicaid. Even the GAO noted that "[w]ithout these funds, the states would have had to appropriate additional state funds or, given reduced federal funds, make cuts in their Medicaid program." GAO/HEHS 94-133, p.2. Accordingly, the reason that neither Congress nor the HCFA have acted to limit IGTs is that all parties recognize that it is unfair to withdraw this source of relief to the states without addressing the larger problem of how to fund the expanding list of federal mandates imposed on the states through Medicaid legislation.

Despite this well documented history of the states' legitimate use of IGTs, your draft report simply ignores that history, discusses none of the reasons IGTs came into existence, neglects to mention the HCFA's acquiescence in the use of IGTs to finance the expansion of Medicaid, and fails to address the fundamental problem of unfunded federal Medicaid mandates. As such, we find your report fundamentally unfair in its presentation and conclusions.

II. THE DRAFT REPORT IS FACTUALLY INACCURATE

There are a number of factual statements in your draft report that are incorrect and lead us to conclude that either you honestly do not understand Pennsylvania's IGT process, or are intent on producing a report that ignores the facts in order to support your biases about this funding mechanism. We address these factual inaccuracies below.

Your description of our June 8, 2000 IGT process is not accurate. You incorrectly assert that our supplementation payments to the county nursing facilities were "not really payments at all." Draft Report, p. 6. Under our IGT program, participating counties transferred approximately $696 million of county-generated revenues to the State Treasury, and Pennsylvania then paid approximately $697 million (including program implementation costs) in net supplementation payments to county nursing facility bank accounts. You fail to note that the bank accounts for each transaction were distinct. Although a single financial institution served as the depository for both the counties' deposit of revenues and the county nursing facility payments, the account into which the program supplementation payment was made was the one designated by the county nursing facility. Accordingly, we did make a payment to the participating nursing facilities.

Your statement that "none of the supplementation payments reached the participating nursing facilities" is based upon your auditors' view of how county nursing facilities should use the supplementation payments, not the final destination of the payment. While the OIG may believe that such funds should be used to improve or expand services, federal law allows providers to use Medicaid payments in any manner they choose. Thus, for example, proprietary Medicaid providers can use Medicaid payments to pay dividends to shareholders. In this case, the payments did, in fact, reach the participating nursing facilities and were used per our Title XIX State Plan and federal law.

Your statement that "Pennsylvania retained the entire $393,342,145 in FFP to use as it pleased" is wrong because what Pennsylvania retained from the transaction was approximately $393 million in **county-provided funds**[1], not $393 million in FFP. Again, the counties transferred $696 million of county revenues to the State Treasury. Pennsylvania then paid $697 million in net supplementation payments to the designated county nursing homes. This $697 million was made up of approximately $304 million in county-provided funds and $393 million in federal funds. This left $393 million of the original county fund transfer in the State Treasury, not federal funds as you inaccurately assert.

[1] We are merely using the term "county-provided funds" to distinguish these funds from federal funds. The "county-provided funds" are, in fact, funds in the State Treasury and, therefore, are "state funds" for the purpose of the IGT transaction.

You incorrectly state that "[i]n effect, federal funds were used to obtain additional funds." Draft Report, p. 8. As noted above, what Pennsylvania retains from the IGT transaction are county-provided funds, and it is these funds that are used to match additional federal Medicaid funds where appropriate. For example, county-provided funds are used to earn federal funds to support nursing home care or home- and community-based services for the elderly since these services are provided to Medicaid-eligible individuals. Services to non-Medicaid-eligible individuals, behavioral health care, and SSI/Domiciliary Care payments, for example, are funded exclusively with county-generated revenue. Let me repeat what we consistently told your auditors, Pennsylvania has not and will not use federal funds to earn federal funds, nor has Pennsylvania used federal funds to provide services to non-Medicaid-eligible individuals.

Your statement on page 5 of the Draft Report that unbudgeted IGT funds are available for "non-Medicaid-related use" is particularly disingenuous, given that you know as a fact that Pennsylvania has historically used IGT funds for health and welfare programs. Nonetheless, for you to make this type of assertion belies any claim of objectivity on this subject by your office. Furthermore, your auditors were told that past practice on this subject would be followed in the future.

Your computation of the FMAP amount in Appendix B of your draft report is also wrong. You should reflect the fact that we do not use federal funds to earn federal funds and show an FMAP rate of 53.84 percent – Pennsylvania's appropriate share – as opposed to the 65.37 percent your analysis incorrectly shows.

I note that the review process employed by your office has not followed usual government auditing standards protocol. We were provided insufficient time to analyze the report, and provided no opportunity to review the work papers from which your conclusions were drawn since you denied our request for these documents. Only seven days (instead of the usual 30) were provided for our review, and this included your mailing date, our receipt day, and two non-business days.

The IGT program was created with the expressed authorization and approval of the HCFA and Congress to help the states pay for new mandates being imposed through the legislative expansion of the Medicaid program. It is not only unfair, but utterly irresponsible, of the OIG to recommend that the HCFA simply abolish the IGT program with no consideration for establishing parameters for which IGT-generated funds may be utilized, and without addressing the larger problem of providing relief to the states from the escalating costs of the Medicaid program.

Sincerely,

Michael Stauffer

Statement of the State of Illinois Department of Public Aid

[SUBMITTED BY ANN PATLA, DIRECTOR]

Mr. Chairman and Members of the Senate Finance Committee, thank you for the opportunity to submit testimony on the Health Care Financing Administration's (HCFA) proposed changes to the Upper Limit/Intergovernmental Transfer (IGT) rules. We in Illinois are proud of our record. We have made tremendous strides in opening up access to health care for Medicaid and State Children's Health Insurance Program (SCHIP) children and families.

Thanks to the commitment of our Governor, our General Assembly, health care providers, community-based organizations, and our federal partners, we provide health care coverage to nearly 10 percent more children, elderly, and disabled individuals than we did one year ago. Access to critical health care services—from immunizations to prescriptions to life-saving transplants—has been increased through our commitment to:

- supporting high volume Medicaid hospitals that also treat a significant number of the uninsured;
- continuing cost-based reimbursement for federally qualified health centers (FQHCs); and
- shoring up the primary care infrastructure in Illinois.

HCFA proposes to reverse more than ten years of policy by abruptly changing a longstanding federal regulation that facilitates the use of "intergovernmental transfers," or IGTs, by states to fund a portion of their share of Medicaid expenditures. This reversal will reduce federal Medicaid funds to Illinois by $500 million dollars per year, forcing the State to cut critical health care services that serve indigent children and families, pregnant women, seniors, and people with disabilities. The loss of these Medicaid dollars will directly impact Cook County Hospital and its clinics—the loss of $200 million to Cook County will have a devastating impact on the health care for the poor in Cook County, the largest and most urban county in Illinois with a population of over three million people.

If this federal regulation is adopted, the loss of funding will devastate the largest health care system in Illinois, operated by Cook County, and will severely impair the State's ability to serve Medicaid participants in all other counties. The State may be forced to: (1) seek repeal of recent health care expansions for the elderly and disabled; (2) retreat from rate reforms that encourage access to preventative and lower cost health care; (3) reduce outreach programs to encourage the use of Medicaid and SCHIP; and (4) substantially cut rates to FQHCs, hospitals, physicians, and other providers who serve Medicaid and SCHIP participants, as well as almost two million uninsured Illinoisans.

Last May, we first became aware that the HCFA was considering this policy change. HCFA's stated purpose in doing so (outlined in a July 26, 2000, letter to State Medicaid Directors) is to close an alleged loophole that has allowed some states to receive funds back from local governments after having reimbursed local government health care providers using, in part, federal matching funds, and to use the transferred dollars to fund non-Medicaid expenditures. But, rather than modifying existing regulations to target such abuses, the proposed change would cast a wide net that ensnares nearly half the states without regard to their specific use of IGTs and Medicaid funds.

For this reason, Illinois Governor George Ryan and other Governors, Congressional leaders, and health care providers all have expressed grave concerns about HCFA's intent to change the rules. To its credit, HCFA has sent the Health and Human Services Inspector General on fact finding missions to better understand how much funding is at stake, how states implement these programs, and whether they comply with federal laws, regulations, and Medicaid state plans. HCFA has begun to gather better information on the proposal's implications, and hopefully will make modifications to target more specifically any abuses of the Medicaid program.

We are particularly concerned with HCFA's characterization of IGTs in general as a "loophole." For ten years, HCFA has been an active partner with Illinois in its IGT program. Over the past decade, HCFA officials have asked all of the right questions and examined Illinois' program in great detail. Over a foot of paperwork has been provided at their request.

Their review of our material has permitted HCFA to approve the Illinois program 22 times over the years. Illinois has known the rules, has played by the rules, and has designed a program that follows all the rules. HCFA designed the rules, has enforced the rules, and has approved numerous Medicaid State Plan amendments (SPAs) in accordance with the rules over the past decade. Thus, it is inaccurate to

characterize Illinois' program as a "loophole," since HCFA has reviewed (in great detail) and approved it multiple times.

The State of Illinois first entered into an IGT agreement with Cook County in 1991. Under the agreement, Illinois' Medicaid reimbursements to Cook County hospitals are patterned after the federal Disproportionate Share Hospital (DSH) and FQHC programs. The DSH program allows payments in excess of Medicaid costs to hospitals that serve a great number of low-income individuals, allowing states to also reimburse hospitals for their uncompensated care. Cook County provides a crucial health care safety net by serving any patient, regardless of his or her ability to pay, and thus is the State's largest provider of uncompensated care at just over $350 million per year.

Similarly, the federal government required states to pay FQHCs at 100 percent of their reasonable costs, until the Balanced Budget Act of 1997 authorized reductions from that standard. Recognizing the importance of such safety net providers, Illinois committed to continue paying FQHCs at the 100 percent level and uses a portion of the State funds gained through Cook County to fund this commitment. Programs such as these are necessary to maintain the viability of providers that serve a majority of low-income clients.

We are anxious for HCFA to issue a rule that will address reported abuses without penalizing states that are using Federal dollars solely to fulfill the mission of the Medicaid program. Illinois has demonstrated that its uses of Medicaid funds—expanding coverage and increasing reimbursement to providers who serve disproportionate numbers of Medicaid and uninsured clients—fall squarely within the latter category.

Yet we currently find ourselves in potentially the worst of all scenarios. Illinois designed its Medicaid program and has created a dependable health care system for its neediest citizens based upon long-standing regulations. The regulatory changes now being considered would, in one fell swoop, undermine the fiscal foundation of Illinois' health care system for the poor.

We believe a rule can be issued that addresses any abuses detailed in HCFA's July 26, 2000, letter. We believe in defending the integrity of the program. We urge HCFA and the Senate Finance Committee to consider Illinois' and other states' health care systems for the poor—these systems were built over a decade of time with Medicaid dollars, 100 percent of which were committed to cover health care services. For Illinois, the consequences of HCFA's proposed rule change are unthinkable.

STATEMENT OF ANTONIA C. NOVELLO, M.D., M.P.H., DR. P.H. NEW YORK STATE COMMISSIONER OF HEALTH

Chairman Roth, Senator Moynihan and members of the Committee, thank you for allowing me to submit these remarks concerning the Health Care Financing Administration's intended actions regarding Upper Payment Limits.

I offer these comments because of the extremely negative impact that regulatory changes currently under consideration by the Federal Health Care Financing Administration (HCFA) would have on the public's health in New York State. I am referring to regulatory changes involving upper payment limits for Medicaid spending.

As was recently acknowledged by Secretary Shalala, New York has long been a national leader in the development of bold and creative health care programs.

I am deeply concerned that changes in HCFA regulations now under consideration will harm these programs and jeopardize the well-being of vulnerable elderly and poor New Yorkers.

Perhaps more than any other State in the Nation, New York's health care delivery system relies on a longstanding partnership of federal, state, local, and private funding. A breach in any of these funding sources has the potential to disrupt every component of the system.

NEW YORK STATE MEDICAID

New York State serves over 2.8 million persons through its Medicaid program. Among these are more than 1.3 million children and more than 1.4 million adults, including 400,000 of whom are elderly.

New York finances its Medicaid program with only a 50 percent contribution from the federal government, the lowest allowable percentage under the Social Security Act. Many states with far less expansive and innovative programs receive a greater percentage of their Medicaid expenditures from the Federal Government.

Since its inception in 1965, New York's approved Medicaid State Plan has required counties to share with the state the burden of the non-federal cost of the pro-

gram. By requiring county governments to finance a portion of the non-federal share of Medicaid costs through direct matching payments for services to their residents, the State has spread the cost of the Medicaid program across several tax bases and encouraged cost consciousness.

This is permissible under both federal statute and regulation so long as the State contributes at least 40 percent of the aggregate non-federal share of Medicaid expenditures.

PARTNERSHIP PLAN 1115 FEDERAL WAIVER

New York State currently operates much of its Medicaid program under an 1115 mandatory managed care waiver known as the Partnership Plan and approved by the Federal Health Care Financing Administration (HCFA) in 1997. Under this waiver, the State is providing a medical home to all participants—Medicaid coverage to persons that would be otherwise uninsured—and is implementing an innovative Community Health Care Conversion Demonstration Program (CHCCDP) to transition health care providers from a predominantly fee-for-service environment to a managed care system.

Under this waiver the State is subject to a budget neutrality calculation, which limits federal financial participation and puts the State at fiscal risk for unanticipated expenditures.

NEW YORK STATE CHIP

In 1990, as part of New York's integrated system of health care financing, the state established an insurance program to benefit poor children who were not eligible for Medicaid. Over the years, this program has been expanded to include a larger population of children and a broader package of benefits.

Our Child Health Insurance Program was the model for the federal child health insurance program included in the Balanced Budget Act of 1997. New York's program now has enrolled 540,000 children—more than one-fourth of the nation's total enrollment in the Children's Health Insurance Program.

Yet the Federal Government has not fulfilled its responsibility for this program. New York is significantly exceeding its 35 percent match required under Title XXI because the Federal Government has not kept pace with the success of New York's program. In 1999, New York's federal allotment was $256 million and the state match was $207 million.

In the current federal fiscal year, New York expects to spend $348 million in state funds and $409 million in federal funds. Without additional federal assistance, New York will spend $541 million in federal fiscal year 2001 while the federal contribution will be only $366 million. This represents a severe imbalance, since the State's contribution will be nearly 60 percent of total expenditures, rather than the 35 percent intended under Federal Law.

It is apparent that the partnership the federal government and the states have entered into is in danger of reaching a severe imbalance.

Additionally, the Federal Government continues to sit on nearly $2 billion dollars in unspent funding—money that should by statute be distributed to states that are exceeding enrollment goals.

THE NEW YORK STATE HEALTH CARE REFORM ACT (HCRA)

New York operates a health care public goods pooling system that provides $2.3 billion dollars in funding annually for hospital and clinic indigent care, physician training in hospitals, the purchase of health insurance for uninsured children and adults, health worker retraining, public health programs, and tobacco control initiatives. The federal Government matches certain pooled HCRA funds to support the medical assistance program, including the money to make disproportionate share payments to hospitals.

FAMILY HEALTH PLUS

There is currently pending before HCFA a waiver to allow New York to expand its Medicaid population further by creating a new program called Family Health Plus. This expansion would provide a health care insurance benefit to the families of children eligible for CHIP and others.

An estimated 600,000 low-income working adults will be eligible for this program when it is fully implemented in 2003.

THE UPPER PAYMENT LIMIT PROPOSAL: A MISGUIDED APPROACH

HCFA's stated goal is to thwart certain States' practices of leveraging federal monies under Medicaid through the use of a local match for increased payments to county providers, then allegedly using the federal monies to support non-health care related programs.

Because HCFA is statutorily prohibited from directly attacking such practices, it is doing so through an indirect back door approach. Namely, it seeks to limit the amount States can pay public providers in the first place, through a change to the upper payment limit methodology.

From my perspective, this is throwing the baby out with the bath water. On a nationwide basis, perfectly legitimate payments to public providers of health care to the poor and frail elderly will be at risk if this proposal is enacted.

It is difficult for me to believe that HCFA can conclusively assert that this proposal will not have a negative impact wholly separate from what it is trying to achieve.

In New York alone, this proposal will diminish the amount that can be paid to county-operated nursing homes by approximately $950 million dollars and diminish federal support for health care in New York by $475 million dollars annually.

Let me make this perfectly clear—every dollar received by New York from the Federal Government, and every associated county dollar, is used directly for medical assistance services.

Specific problems with the use of federal Medicaid monies should be dealt with directly through appropriate legislative channels. They should not be dealt with through indirect, broad-brush, back-door mechanisms that will have a negative impact on States' health care programs and the viability of vulnerable public providers.

The current Upper Payment Limit (UPL) methodology allows states flexibility to set rates across broad classes of providers and target additional funding where needed, particularly to providers of last resort whose costs are traditionally higher than others.

If the State suffers a loss of $475 million in federal Medicaid funding, it would create a major void in the state's health care system, which leads the nation in providing care to uninsured children and adults, subsidizing indigent care, and assuring quality health care services for the elderly and disabled.

HCFA's plan to reduce this funding is a particularly difficult for New York to understand as it has achieved so much in the area of innovative health care despite having the lowest Federal Medicaid Assistance Matching Percentage (FMAP) in the nation.

Although a reduction of $475 million in federal funding can be argued to be a relatively small percentage of New York's gross Medicaid spending, in terms of how this money benefits people in the state's programs, this amount is enormous.

A reduction in federal Medicaid funding of $475 million:

- could cause significant problems for county-operated nursing homes and a reduction in available beds for the poor, vulnerable and frail elderly who utilize these facilities;
- could lead to the loss of momentum in New York's enrollment efforts for its Children's Health Insurance Program, called Child Health Plus;
- could delay the implementation of New York's Family Health Plus Program for low-income, uninsured working adults; and
- coupled with Federal Medicare cuts to New York Hospitals, could seriously impact the finances of New York's hospitals and their ability to serve indigent and vulnerable citizens.

STATUTORY CONSIDERATIONS

As early as 1990, HCFA decried the "inappropriate" use of local funds to draw federal monies. In fact, HCFA is now using almost verbatim the argument it used in its abortive 1991 rulemaking attempt to address this and other issues.

As a result, Congress expressed its intent that HCFA not limit the ability of states to use local funds as long as no more than sixty percent of the non-federal share of payments is derived from sources other than state monies.

The Congressional mandate expressed in Public Law 102-234 is clear:

> " . . . the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes . . . transferred from or certified by units of government within a state as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider . . . "

I believe that HCFA must work with Congress to amend this provision if it wishes to deal with the alleged "egregious" practices it is trying to stop. Further, I believe it is time for Congress to remedy the inequities in the statutory formula by which states are allocated a federal share of Medicaid.

Thank you.

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